

NURSES AS NEIGHBORS:
COMMUNITY HEALTH AND THE ORIGINS OF SCHOOL NURSING

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by
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This dissertation examines the origins and development of school nursing as an outgrowth of Progressive reform, especially in the settlement house movement. The Progressive stories of the rise of nursing and the transformation of public education have traditionally been told separately, but they come together in the person of the school nurse.

School nursing was the brainchild of nurse Lillian Wald of the Henry Street Settlement, who had created a visiting nurses' settlement because she wanted both to treat individuals and to help transform the social conditions that contributed to their poor health. Eventually she came to believe that education and health were the twin pillars of reform; both were essential to democracy, since civic participation depended on schooling, but without healthy bodies, children could not learn. Ultimately, Progressive nurses believed that health, like education, should be in the realm of the government, and that once they had achieved the success of compulsory education, universal health care would be right around the corner.

Thanks to Wald's efforts, in 1902, Lina Rogers became the first municipal school nurse in the world. Although visiting nurses had previously performed many of the same duties in the homes that school nurses then did, the school nurse indicated a

change in responsibility: while settlement houses were funded by benefactors, nurses and doctors in the schools were paid for by the city. Rogers' program paved the way for future city and state programs such as the ones run by Dr. Sara Josephine Baker at the New York Division of Child Hygiene and later at the Federal Children's Bureau. Rogers and her colleagues became powerful forces for inclusion as they helped to redefine what communities meant in American culture. The school nurse captured the Progressive belief that the state had a responsibility to provide both education and health care to all, and that public education and public health were inseparable.

BIOGRAPHICAL SKETCH

Heather Furnas received her B.A. in History and Latin American Studies from the University of Nebraska-Lincoln in August 2000. She received her M.A. in 2006 and her Ph.D. in 2014, both from Cornell University.

For Alex

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Libraries far and wide helped make this research possible, but Cornell University Library has been my home base, and I am very grateful to the library as a whole and to the individual librarians who have been such help to me. This dissertation would not have been possible without the staff at Olin Inter-library Loan Services. I can't thank them enough for the hundreds of reels of microfilm and countless rare publications, in addition to all of the books and articles. If it existed, they found it. Thanks for bringing it all to me so that I could do research on my lunch breaks rather than having to travel hundreds of

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documents over the years in her capacity as head of inter-library loan, also became a great friend; during the writing process, she provided endless cheerleading, and even an icy late-night rescue. She also read every word of the manuscript, giving me great insights and lending me her keen eyes for editing and proofreading.

My mother, Mary Furnas, has always believed in me and had my back no matter what, and my younger brother, Kevin, and his wife Charity, have been my advocates. My father, Tyrone Furnas, considers me capable of taking on the world, and his confidence has sustained me; thanks also to my aunt, Allison Hayes, who showed me a love of local history early on in life. My in-laws, Colleen and Bob Proehl, took me in as their first girl, and have offered a home away from home.

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Introduction

The school nurse and the intersection of state and medicine

OMI
Délegation Régionale de TOULOUSE
19, Chemin Lapujade
31200 TOULOUSE

CERTIFICAT MEDICAL

Dossier N° : 440104000699
Procédure : 01-Autre Etranger
Référence Préfecture : 3103068393
Nom : FURNAS épouse RATEL
Prénom : HEATHER
Née le : 21/10/1977
Nationalité : AMERICAINE

Remplit les conditions sanitaires pour être autorisée à résider en France.

Le médecin,
Date: 13 JAN 2005
Vu, le Délégué Régional,
Tadek DABKOWSKI
OFFICE DES MIGRATIONS
INTERNATIONALES
TOULOUSE

Destinataire : Intéressé
OMI - IC7

TREASURY DEPARTMENT
Public Health and Marine-Hospital Service
Form 555B

MEDICAL CERTIFICATE

Port of Baltimore, ,
12/21, 1905, 190

Name, Prune Keiles
Age, 8 Native of Russia Race, Hebrew
S. S. Neckar
Arrived Sept. 29, 1905. (Cert. Trachoma, 10/9/05)

This is to certify that the above-described immigrant has
no longer a dangerous contagious disease

(Sd) J. W. Schereschewsky,
P. A. Surgeon, P. H. and M. H. S.

To the Commissioner of Immigration.

COPY. IMMIGRATION SERVICE
RECEIVED

Medical certificates: Toulouse, France, 2005;
Baltimore, United States, 1905.¹

My interest in school nurses on the Lower East Side did not begin because of a connection to an immigrant experience here in America, least of all in New York City. My forebears never passed through Ellis Island, never planted themselves in one of the urban ghettos full of recent arrivals. The only migration that my family recalls is the one from Ohio—when Robert Wilkinson Furnas traveled to Nebraska in the 1850s as a newspaper man, or at least a pioneering spirit intent on

¹ “Typical Immigrant Medical Certificate,” 1905, RG 90, National Archives and Records Administration. Found in: Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: Johns Hopkins University Press, 2003), 2.

bringing others further West through his weekly, *The Nebraska Advertiser*. No, my ancestors are fully embedded in the American middle, and our family has the same land in its hands now that Robert Wilkinson did then.

I came to this project by way of my own experience as a foreigner, which was unlike any encounter with the “state” that I had ever had in Nebraska or New York, where all of the institutions were familiar, and where my own place as a citizen gave me the blindness of someone with unquestioned belonging. I moved to France with my French partner and infant son; I started on a tourist visa, but later had to get it extended, and then I wanted to work. I spent hours waiting at Immigration, fulfilling ridiculous requirements and performing bureaucratic gymnastics; I was sent away for more paperwork or summoned to the office at their whim, date and time stamped on the letter. I stood in long lines; I sat on benches. And finally, I approached the desk of the immigration officer, who looked down at me from her raised platform behind the glass. The power dynamic was consistently enforced, and just like on Ellis Island, it was not meant to be humane, it was meant to be efficient and to impart a message. Waiting in the summer heat, we knew that we were there as guests, there to request the magnanimity of the French state. France was experiencing an influx of immigration from its former colonial outposts across the Mediterranean, especially Algeria and Tunisia, and like other countries in Europe, was looking to slow it.

As part of my visa requirements, I also had to get a medical inspection. It did not take place there in the Immigration office. Instead, I had to request an appointment, and later they sent me a letter in the mail and told me when to arrive. I got my eyes checked; I was weighed and questioned. I was told that they weren’t going to deport me if I had a problem, they just wanted to find out about it so I could get treatment. I didn’t quite believe them. I left that day

with a life-sized x-ray of my lungs, proof that I did not have tuberculosis. I carried it with me on the bus, hidden in an oversized envelope that I then had to carry to my teaching job, then back home on the metro, a large-as-life passport for my sojourn in the country. I had it in its manila envelope until the day I left France, unsure what else to do with it.

To further test my fitness for entry, on the same visit I went to another room to discuss the rest of my visa requirements and to evaluate my French language skills. It was a brief conversation with a handsome bureaucrat that no doubt included a bit of French flirtation, but I did leave with a certification of my fluency in French. I was also told what else I would have to do if I ever wanted citizenship. At that time, one could apply after two years of marriage to a French citizen; by the time I had actually been married two years, the requirement was changed to four years, a reaction against the “riots” in the *banlieus* and the problem of integration of the children of all these immigrants.

At that time I also signed up for my required Civics class. They offered one with English translation, but my French was good enough that I could enroll for a time slot that was more convenient for me, which happened to be the course with Arabic translation. The most striking part about my class (I don’t remember any of the details except the elaboration of the meanings of Liberté, Égalité, Fraternité, and—I don’t know if they added this on as extra just for this class—Laïcité) was that I was the only female participant whose head was not covered—the rest of the women were Muslim and wore head scarves. And then their husbands came and sat beside them. At first I did not understand what was happening, but as the class began and attendance was taken, it was revealed that there were extra people in the room. And despite objections that the men could translate, or that they always stayed with their wives, the representatives of the state insisted that only the person who was seeking a visa or citizenship was allowed to sit in.

One person before the state in France. I will never forget that unabashed enforcement of civic values over cultural practices. When I went to leave the building at the end of the workday, some of the men were still waiting there for their wives.

Like I learned in my civics class, France has a strong sense of its own values, which extended to its institutions. I wanted to take advantage of the French school system, especially the *maternelle*, in which toddlers could enter National Education the year they turned 3. Born in December, Alex was able to have access to full-time preschool education and after-school care when just 2 ½ years old. It was public and free, unlike the private daycares in the U.S.

The differences in the relationship between French and American conceptions of the private and the public were made very clear. In France, as I should have known from the grammar of the language itself and the reminders in the civics class, there is a different set of rules for public life and private life. Picking up my son from school one day, I helped him into his shoes and backpack, and chatted with him in English. His schoolteacher came by, and in that sing-song way of tut-tutting old ladies, said: “On parle que français à l’école.” *We speak only French in school*. For the French state, the gates of the school were the entryway into a public institution, so public rules applied; but to me, speaking to my child was private, no matter what building I was standing in.

I recognized my own cultural privilege as an American in Europe, an American who spoke English; a white all-American girl with an all-American set of Midwestern teeth, and a cultural arrogance to match. When the teacher told me that we speak only French in school, I had a strong enough sense of myself and my rights as a parent—you know, the ones they teach us about in American schoolrooms—that I could ignore her. I was not a mother from a North African country, countering a history of colonial racism, and I had nothing invested in

identifying myself as a French citizen. I was just a parent picking up my child from school. But I was also aware of the difficulties that my own recalcitrance caused my son. Unfamiliar with the protocol of salutations that make or break relationships in French society, I wasn't in the habit of saying "bonjour" to the principal when I walked in with the masses of other parents in the morning. I was chastised through my child, who got in trouble for not greeting her properly when he walked through the gates of the school: "Bonjour, madame," she modeled. He was not even three when he started *maternelle*, and, like many children in bilingual households, was a late talker. But he complied, and from then on, so did I.

The health system in France was also much more socialized than I was used to, and when that state involvement in medicine abutted the nationalized educational system, it upset my ideas about the authority of parents over their children. I had never thought much about medicine before I became a mother myself. When I was a child, my mom made sure that I saw doctors for annual check-ups and updated vaccinations, and I got the required physicals to participate in sports. The school nurse checked me for scoliosis and head lice, and let me lie down with a mercury thermometer that smelled of rubbing alcohol plunged under the tongue. Pregnancy had been my first extended encounter with medicine as an institution, and even then all of my objections were met with cooperation; in a medical system driven by consumer demand, Ithaca was the perfect place to have a natural childbirth, where the hospital had to respond to the competition of the homebirth midwives and birthing centers thriving around it. I was the authority over my child; no procedure was done without my permission, and I had the confidence that even hospital policy could be thwarted if I really wanted it to be.

My understanding of parenthood, it turns out, is very American. I believe that I am the ultimate authority over my child, and that my decisions for his wellbeing should be respected

above all others. If I did not want to vaccinate my child for school, I knew that there were ways in the United States to get around requirements—I didn't know what they were, but that was how I understood it to be. But as we filled out the paperwork for school in France, it became clear that there were certain vaccinations that would be mandatory, despite any reasonable objections I might have. My son is vaccinated, but in France, a tuberculosis vaccine was required for school, which would have caused bureaucratic troubles for us returning to the United States since he would have tested positive for the disease. Despite frustrations and arguments, the only way we got around it was that we waited long enough for the pharmacies to run out, and a note could be put in his file until later in the year. By the time the issue would have come up again, we had left the country.

For me, this experience defined the questions that are the foundations and framing of this dissertation: Where is the line between the public and private spheres? What is the role of the state in medicine, especially when the state intervenes over the wishes of parents? There are a few different dimensions to each of the questions to address here. The first is about the state intervening in individuals' lives for the common good, which for children and health most often comes up with regard to vaccination. Each individual child must be vaccinated to create a "herd immunity" that ultimately prevents an epidemic of a disease. The other aspect of this same issue is that of protecting the less healthy from diseases that the healthy might fight off on their own. We often hear of those with "weakened immune systems"; usually this is punctuated with a colon and a list of those affected persons, like pregnant women, children under the age of five, senior citizens, and those with certain conditions or illnesses that compromise the ability to fend off disease. While a robust child in elementary school can easily survive the chicken pox, there

might be others in the community who cannot; measles may not permanently harm a child of ten, but the fetuses of pregnant women are in danger. The healthy are vaccinated in order to protect the less healthy, although who the “healthy” are and who the “less healthy” are shifts according to the illness. The flu pandemic of 1919, for example, affected the group usually considered to be the most resilient of all: teenagers and adults. While usually babies and the elderly are at risk for most illnesses, they survived the flu in greater percentages than young men coming back from the war. Working together as a community is necessary to prevent epidemics, so the reasoning goes.

But there is another kind of intervention in the rights of the individual versus the state, and that is when an authority steps in to make decisions for children over the parents. Who gets to decide for a person who cannot decide for him/herself? What are the limits of the rights of the parents to make decisions over the lives of their children? What about the cases of parents who refuse to treat their children? Whose rights are more important, the parents’ or the children’s? These are not exceptional questions—these are questions that get raised all of the time in schools and family courts, among social workers and child protection services. And certain kinds of regulations on families are enforced by the state in subtle ways, such as simply requiring all babies to get silver nitrate in their eyes at birth. These are regulations enforced in ways to make them look as if they are requirements on midwives and hospitals (which they are) but if you look closely, or resist strongly, they look like stepping over the rights of parents who should get to decide in these matters.

That said, don’t we want some responsibilities taken out of our hands? In the last election, Rick Santorum said that public schools are more like factories; they should be abolished

and all parents should home school.² The tyranny of unhindered choice, a concept first introduced to me in the history of consumerism, also seems to apply in other arenas of life, where a seemingly unlimited number of rights mean a burdensome number of unshared responsibilities. Steven Waldman called the contemporary consumer experience a “choice explosion,” and as he complained, “choice can be profoundly debilitating.”³ If I take all of my “rights” as a parent to mean sole and authoritarian control, how do I find time to do anything else with my life? There are certain responsibilities that I am willing to take on as a parent—feeding my child, cuddling with him, reading to him, and much more. But schooling him? Besides the obvious question of how I could make money to give him a place to live while learning his ABCs, this is a responsibility that I am less willing to take on, just as I don’t want to build my own roads, fight my own fires, or deliver my own mail.

Does that make me a bad parent? Some might say yes. Some might say that my duty as a parent, particularly as a mother, is greater than all other responsibilities, that it is a sacred duty that must override all other obligations. And while I do not consider myself a bad mother—any more than most good mothers do—I have of course had moments of lofty judgment against other mothers, particularly in France, where the state carries a much greater share of child-raising than they do in the United States, and where the mother + father + child triad is not the shape that dominates family life. But, oh yes, did I judge when mothers would send their infants off to stay with grandparents while *maman* and *papa* took a vacation. “*La couple*” has a much greater

² Mitchell Landsberg and Seema Mehta, “Rick Santorum Plays Hard to Conservative Base in Ohio: He Takes Shots at Republican Rival Mitt Romney and President Obama, and Refers to Public Schools as ‘Factories,’” *Los Angeles Times*, February 19, 2012, <http://www.latimes.com/news/nationworld/nation/la-na-gop-race-20120219,0,2831889.story>.

³ Steven Waldman, “The Tyranny of Choice,” in *Consumer Society in American History: A Reader*, ed. Lawrence B. Glickman (Ithaca and London: Cornell University Press, 1999), 359–66.

importance in French family life; parents are more willing to share the burden of raising their children than most Americans are, and leaving a child at school or with extended family does not constitute bad parenting, but quite the opposite.⁴ In fact, to privatize education and remove children from schools would also cut them off from an important introduction to civic and social engagement. Sole authority is also a solitary existence, both for parents and their children. School is a place of community, and can provide increased opportunities not only to learn from others, but to participate in a social world. We share these responsibilities to lessen the load of individual parents, to expand opportunities for children, and to be a part of the public sphere.

Education is another arena of French life where the state takes on a greater part of the responsibility than it does in the United States, at all levels, but especially preschool education. I could holler up and down about why universal pre-school education is so important, but most crucial for me is that it takes the burden off parents to educate their children in the early, most important years, which eliminates some of the inequality among the parents who are raising the children. We would like to believe that we all have an equal shot in the world, but it is clear by kindergarten that some kids are going to do better than others. Studies have shown that children who are at the top of the class by kindergarten will probably be at the top of the class by

⁴In the same vein, Denise Segura discussed the ways in which women raised in Mexico and women raised in the United States have different conceptions of what makes a good mother. Segura demonstrated that Mexicanas, or women born in Mexico and working in the United States, see themselves as good mothers because they are participating in the labor market and thus providing for their children financially even if at the cost of time with their children. In contrast, Chicana mothers, women of Mexican heritage but raised in the United States, have taken on the American ideologies of the nuclear family and household wage economy that insists that mothers who cannot stay at home with their children are not good mothers. Denise Segura, "Working at Motherhood: Chicana and Mexicana Immigrant Mothers and Employment," in *Feminist Frontiers*, ed. Laurel Richardson (McGraw Hill, 2004).

graduation as well.⁵ French schools work to eliminate some of that inequality by giving all children access to early education.

Thus, when I attended a parent-teacher meeting at the French *maternelle*, and the teacher described how they were teaching early letter recognition, I raised my hand and asked the obvious American-parent question: “What should I be doing at home?” And the answer was: Nothing. I was shocked (I still am, in a way). But when I think of the advantages that my son would have had over other children (other immigrant children, for example, whose parents may not have been able to read or write French) because he has educated parents who are surrounded by books and who are trained as teachers, it seems now perfectly reasonable to expect that the state—the school—should equalize these opportunities by making early education free and available to all, and so comprehensive that parents didn’t need to add to it through homework and special lessons. Unlike the excellent school my son now attends in Ithaca, which has successful students and amazing teachers but is dependent on the participation of highly involved parents who may not be financially wealthy but who are rich in cultural capital, French schools acted without parent volunteers, or even much parent involvement. In fact, they literally locked the gates behind us as we walked out, and when it was time to return to pick up our children, we waited more or less patiently, attempting to peer through the grates until they allowed us in.

All of this is to say that as an American parent in France, I was surprised by the interventions of the French state that usurped what I understood my rights as a parent to be, but in the United States, I am appalled by the lack of responsibility of the state to provide the services which I had come to see as essential for children. So, yes, there is a price to pay: a parent must exchange her exclusive authority in order to gain access to medical care and

⁵ Elizabeth Weil, “When Should a Kid Start Kindergarten?,” *The New York Times Magazine*, June 3, 2007, <http://www.nytimes.com/2007/06/03/magazine/03kindergarten-t.html>.

education, just as I exchange exclusive rights to my income to pay for the roads and fire departments. But what are the limits of these exchanges? How did certain of these regulations come to be instituted in France and not become accepted in the United States?⁶

There is no better historical period through which to study these issues than the Progressive Era, when two movements converged that required the limitations on certain individual rights: the rise of the regulatory state and the rise of the public health movement.⁷ One could arguably say that these are two sides of the same coin, since the public health movement could never have achieved its successes without the active intervention of the government. In fact, public health was crucial to the movement to create a more regulatory state, because it was an arena in which people were willing to give up some rights for greater protections, even across classes. The rich might have complained about regulations in housing, which were protections mostly for the poor at the cost of the landlords, but tropes of contagion certainly went the other way—the protection of the rich against what were considered to be the filthy, diseased poor, even when in reality protections effected greater lifestyle changes for those in poverty.

⁶ I am certainly not the first to ponder the differences between European and American versions of welfare policies. Alisa Klaus tackled the comparison between the United States and France. Alisa C. Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890-1920* (Ithaca, N.Y: Cornell University Press, 1993). Jane Lewis gave an excellent analysis of the development of English maternalist policies. Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (Montreal: McGill-Queen's University Press, 1980).

⁷ The convergence of these movements had serious consequences for individual rights. Fairchild, *Science at the Borders*; Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston: Beacon Press, 1996); Mary E Odem, *Delinquent Daughters: Protecting and Policing Adolescent Female Sexuality in the United States, 1885-1920* (Chapel Hill: University of North Carolina Press, 1995). This intervention did not go unprotested. Robert D. Johnston, *The Radical Middle Class: Populist Democracy and the Question of Capitalism in Progressive Era Portland, Oregon*, *Politics and Society in Twentieth-Century America* (Princeton, N.J: Princeton University Press, 2003); James Colgrove, "'Science in a Democracy': The Contested Status of Vaccination in the Progressive Era and the 1920s," *Isis* 96, no. 2 (June 1, 2005): 167–91.

Overall, progressive reformers wanted to expand the role of the government in the lives of individuals and to create a more regulatory state to protect against corporate greed and oligarchy; they argued that the role of the government should be to balance individual rights with the well-being of the community, or to “use Hamiltonian means for Jeffersonian ends”; that is, to use centralized government to promote democracy.⁸ In order to succeed, they had to redraw the boundaries between public and private spheres and challenge the philosophy of individual rights and that of the non-interventionist state that had existed since the American Revolution.⁹ For example, in 1890, one might have argued that only the parents should decide whether or not children should be sent to school. One might also say that the government should not be able to legislate an eight-hour workday. Under this political philosophy, private property was sacrosanct, and therefore impervious to regulation by a city government, even if it meant families had to live in dangerous tenements without clean air and water. Similarly, the producer set the only standards for food, so a dairy farmer might set his own quality standards, but mothers could not be guaranteed that milk would be safe for their children to drink.

⁸ Herbert Croly, *The Promise of American Life* (New York: Macmillan, 1909).

⁹ Daniel T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge, Mass.: Belknap Press of Harvard University Press, 1998); James T. Kloppenberg, *Uncertain Victory: Social Democracy and Progressivism in European and American Thought, 1870-1920* (New York: Oxford University Press, 1986); Alan Dawley, *Struggles for Justice: Social Responsibility and the Liberal State* (Cambridge, Mass.: Belknap Press of Harvard University Press, 2000). Rodgers called this the “twilight of laissez-faire” and explored the economic underpinnings of this shift as it was brought about through German-trained economists. Kloppenberg explored the philosophical shift by discussing how several philosophers “transformed liberal theory into progressive theory” that he called *via media*. “From a doctrine based on the idea of natural rights and culminating in the idea of a noninterventionist state, these thinkers turned the old liberalism into a new liberalism, a moral and political argument for the welfare state based on a conception of the individual as a social being whose values are shaped by personal choices and cultural conditions (299).”

With that philosophy in mind, progressive reformers sought to regulate working conditions and to provide workers with more protections, limiting the rights of employers in order to save workers from dangerous conditions. They wanted housing laws to protect families living in hazardous tenements, meaning that the state had to limit the rights of landlords to ensure those of tenants. They fought for federal food and drug laws to protect consumers. Finally, progressives thought the government should regulate child labor and make education compulsory because the future of the democracy depended on a populace that was educated, even if that was not what the parents or the employers wanted. In sum, the government must intervene for the good of society, because unchecked individualism led to inequality and ultimately threatened democracy.¹⁰

But reformers did not simply want to limit and control, they also wanted to expand the role of the state to provide services that were previously not considered to be public concerns, particularly the care of women, children, and health: these were considered private concerns, the concerns of the home, the concerns of women.¹¹ First through kindergartens and well-baby clinics provided by local reformers, and expanding to national structures of maternal and infant health like the Sheppard-Towner Act, children's health was moved out of the responsibility of the individual mother and was shared by other members of the community. As Glenda Elizabeth Gilmore summarized, the Progressive Era was a time when there was a "redrawing [of] the boundaries between public and private." This meant a new understanding of "what men should

¹⁰ Glenda Elizabeth Gilmore and Richard Hofstadter, eds., *Who Were the Progressives?* (Boston: Bedford/St. Martin's, 2002).

¹¹ Gordon argued that reformers actually put children ahead of women's issues, which hindered the benefits of the welfare system as a whole. Linda Gordon, "Putting Children First: Women, Maternalism, and Welfare in the Early Twentieth Century," in *U.S. History as Women's History: New Feminist Essays*, ed. Linda K. Kerber, Alice Kessler-Harris, and Kathryn Kish Sklar (Chapel Hill: University of North Carolina Press, 1995), 63–86.

do and what women should do” and “what government should do and what it should not do.”¹²

Maternalist reformers expanded the conception of domesticity, and also by doing that, they moved what many would have considered private concerns like health, education, and housing into the public sphere, making those the responsibility of the state.

Critics of these policies rightly point to the problems with state involvement in personal affairs. Much of the criticism of the “child savers” of the Progressive Era centered on the overpowering state institutions that caused undue conflict between parents and the state and created a white middle-class standard of family and home. In this version, meddling social workers and juvenile court systems sent children to orphanages and reform schools and disrupted immigrant life.¹³ The state had permission to police the morality of adolescent girls and caused conflict between parents and teenagers.¹⁴ Advocates of child labor reform and protective legislation utilized their own vision of the “priceless child” and put forth their own gender standards to measure poor and immigrant mothers.¹⁵ This tension between aid and intervention is constantly present in the analysis of these policies.

¹² Glenda Elizabeth Gilmore, “Responding to the Challenges of the Progressive Era,” in *Who Were the Progressives?*, ed. Glenda Elizabeth Gilmore and Richard Hofstadter (Boston: Bedford/St. Martin’s, 2002), 11.

¹³ Tony Platt, *The Child Savers: The Invention of Delinquency* (Chicago: University of Chicago, 1969); David Nasaw, *Children of the City: At Work and at Play* (Garden City, N.Y: Anchor Press/Doubleday, 1985).

¹⁴ Odem, *Delinquent Daughters*; Regina G. Kunzel, *Fallen Women, Problem Girls: Unmarried Mothers and the Professionalization of Social Work, 1890-1945* (New Haven: Yale University Press, 1993); Ruth M. Alexander, *The Girl Problem: Female Sexual Delinquency in New York, 1900-1930* (Ithaca: Cornell University Press, 1995).

¹⁵ Viviana Zelizer traced this changing conception of the role of the child in the family from one of a working participant in the family economy to a precious being worthy of adoration, and whose childhood is a sacred time that should be protected. The individual child was no longer seen as an “object of utility” but an “object of sentiment.” Viviana A. Rotman Zelizer, *Pricing the Priceless Child: The Changing Social Value of Children* (New York: Basic Books, 1985).

A part of this critique is that policies were distributed unevenly among different social groups. The race and class dynamics cannot be overlooked, since most of the reformers were middle-class white women with some higher education, interfering in the affairs of immigrants and people of color. Although some settlement house workers, like Jane Addams and Lillian Wald, had racially integrated programs, most did not.¹⁶ Meanwhile, most of the recipients of these reforms were poor immigrant women, and the policies looked a lot like Americanization. They were encouraged to cook certain foods, keep their households in an impossibly orderly way, and mother their children according to white middle-class standards of childrearing.¹⁷

While reformers certainly did impose a particular set of values on immigrant families, they did so more in the language of rights than in the language of limitations. While they did try to homogenize differences into middle class values, they did so thinking that the standard of life that they lived deserved to be shared by all, not limited to a few. The study of the origins of school nursing is a way to access the narratives of the individuals involved in this process of bringing programs from the arena of philanthropic charity to municipal control, and shifting the balance from the private arena to the public.

Maternalist agendas paved the way for women's participation in the public sphere.¹⁸ But more than that, they brought with them a more embracing definition of public, one in which

¹⁶ Elisabeth Lasch-Quinn, *Black Neighbors: Race and the Limits of Reform in the American Settlement House Movement, 1890-1945* (Chapel Hill: University of North Carolina Press, 1993).

¹⁷ Katrina Irving, *Immigrant Mothers: Narratives of Race and Maternity, 1890-1925* (Urbana: University of Illinois Press, 2000); Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca, NY: Cornell University Press, 1995); Noralee Frankel, ed., *Gender, Class, Race, and Reform in the Progressive Era* (Lexington, Ky: University Press of Kentucky, 1991).

¹⁸ Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991); Kathryn Kish Sklar, *Florence Kelley and the Nation's Work* (New Haven: Yale University Press, 1995); Seth Koven and Sonya Michel, eds., *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge,

responsibility for concerns like education and health could be shared communally, rather than being limited to the burden of an individual family. The progressive discourse that challenged a

1993); Laura L. Lovett, *Conceiving the Future: Pronatalism, Reproduction, and the Family in the United States, 1890-1938* (Chapel Hill: University of North Carolina Press, 2007); Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana, Ill.: University of Illinois Press, 1994); Gordon, "Putting Children First: Women, Maternalism, and Welfare in the Early Twentieth Century"; Mimi Abramowitz, *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present* (Boston: South End Press, 1992); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass: Belknap Press of Harvard University Press, 1992). Estelle Freedman wrote that the settlement house movement best illustrated "the process of redefining womanhood by extension, rather than by the rejection, of the female sphere." Estelle Freedman, "Separatism as Strategy: Female Institution Building and American Feminism, 1870-1930," *Feminist Studies* 5 (Fall 1979). Other historians used Mary Beard's term "municipal housekeeping" to describe women's role in the sanitarian movement in which women worked to clean up the urban environment using the same skills they used to clean and manage their own homes: Suellen M. Hoy, *Chasing Dirt: The American Pursuit of Cleanliness* (New York: Oxford University Press, 1995); Suellen M. Hoy, "Women as Municipal Housekeepers," in *Pollution and Reform in American Cities, 1870-1930*, ed. Martin V. Melosi (Austin: University of Texas Press, 1980), 173-76; Juliann Sivulka, "From Domestic to Municipal Housekeeper: The Influence of the Sanitary Reform Movement on Changing Women's Roles in America, 1860-1920," *Journal of American Culture* 22, no. 4 (Winter 1999): 1-7. For articulations of women's role in the public sphere in earlier eras, see: Nancy F. Cott, *Bonds of Womanhood: "Woman's Sphere" in New England, 1780-1835* (New Haven: Yale University Press, 1977). Barbara Welter, "The Cult of True Womanhood: 1820-1860," *American Quarterly* 18, no. 2 (July 1, 1966): 151-74; Shelia M. Rothman, *Woman's Proper Place* (Basic Books, 1980). Mary Ryan called women who wanted to be mothers to the whole world "social housekeepers." Mary P. Ryan, *Womanhood in America: From Colonial Times to the Present* (New York: New Viewpoints, 1975), 142-147, 226-235. Daniel Scott Smith coined the term "domestic feminism" to describe early advocates who kept their arguments for women's education carefully guarded within domestic expectations, but set the stage for others to make claims outside the home. Daniel Scott Smith, "Family Limitation, Social Control, and Domestic Feminism in Victorian America," in *A Heritage of Her Own: Toward a New Social History of American Women*, ed. Nancy F. Cott and Elizabeth H. Pleck (New York: Simon and Schuster, 1979), 222-45. Paula Baker argued that the transition from "public motherhood" and "social housekeeping" to maternalist agendas occurred during the Progressive Era, when reformers realized that they couldn't make these changes without the aid of state policy. Paula Baker, "The Domestication of Politics: Women and American Political Society, 1780-1920," *The American Historical Review* 89, no. 3 (June 1, 1984): 620-47. Linda Kerber traced historians' usage of the metaphor of separate spheres from the 1960s to the 1980s, and challenged the categorization of separate spheres more generally, arguing, among other points, that it evaded the question of race and focused too much on white, middle-class women. Linda K. Kerber, "Separate Spheres, Female Worlds, Woman's Place: The Rhetoric of Women's History," *The Journal of American History* 75, no. 1 (June 1988): 9.

harsh laissez-faire understanding of economics also challenged an individualistic understanding of family life. Family had a more expansive meaning, and instead of being contained in a home, it was contained within a neighborhood, and by extension, the legal arm of community: the state. As feminist Retha Childe Dorr explained in 1910: “Women’s place is Home. ... But Home is not contained within the four walls of an individual house. Home is the community. The city full of people is the Family. The public school is the real Nursery. And badly do the Home and Family need their mothers.”¹⁹ Maternalist reformers had strong visions of what the role of the state should be in the lives of children and families. This study, which moves from neighborhood to nation, traces the way in which a few women conceptualized and enacted that process of bringing private concerns into the public sphere.

Long before women’s suffrage in 1920, progressive reformers created a space in the public sphere by developing a whole new set of professions, giving women with an education a way to use their skills.²⁰ Robyn Muncy argued in *Creating a Female Dominion in Reform* that

¹⁹ Baker, “The Domestication of Politics,” 632.

²⁰ Muncy, *Creating a Female Dominion in American Reform, 1890-1935*; Sklar, *Florence Kelley and the Nation’s Work*; Allen Freeman Davis, *Spearheads for Reform: The Social Settlements and the Progressive Movement, 1890-1914*, Reprint (New York: Rutgers University Press, 1984). Ellen Fitzpatrick told the stories of Frances Kellor, an expert in the budding field of criminology, Grace and Edith Abbott, Katherine Davis, and Sophonisba Breckinridge, all social scientists that worked in reform. Ellen F. Fitzpatrick, *Endless Crusade: Women Social Scientists and Progressive Reform* (New York: Oxford University Press, 1990). Edith Abbott was an economist and social scientist and studied delinquency, criminality, and immigration. Her sister Grace Abbott was an expert on immigration and child welfare, and would lead the Children’s Bureau. Lela B. Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (Urbana: University of Illinois Press, 1983). While social science was one important avenue, other women with advanced training but limited in their professional opportunities, especially in the sciences, also found work by transferring their skills to reform activities. Alice Hamilton was a medical doctor who would lead the way for industrial medicine and factory investigation, and chemist Ellen Swallow Richards invented Home Economics. Barbara Sicherman, *Alice Hamilton, a Life in Letters* (Cambridge, Mass: Harvard University Press, 1984); Margaret W. Rossiter, *Women Scientists in America: Struggles and Strategies to 1940* (Baltimore: Johns Hopkins University Press, 1982). Julia Lathrop would leave Hull House to lead the Children’s

this shaping of space was a response to a line of hegemonic gender ideologies that women had to work within to make room for improvements in equality. Just as the Cult of True Womanhood allowed women to form all-female voluntary associations in order to enter the public sphere within a gendered understanding of morality, the reform “dominion” of the twentieth century allowed for a limited number of professions that were still considered women’s work.

Muncy used the term “dominion” to evoke both “autonomy and circumscription.”²¹

Women were gaining more authority in certain arenas, but were hindered by male policymakers at all levels. In the realm of child welfare policy at the national level women reformers were limited by male legislators; at the micro-level, female nurses were hindered by male doctors, and teachers by boards and principals. Professionalization, which was a hallmark of the Progressive Era, was at odds with many of the traditional understandings of female behavior, which kept women out of many of the more prestigious professions and limited workplace opportunities.

Settlement houses, however, were spaces where women could use their educations and develop their careers in a circumscribed and primarily feminine space. They were the hotbeds for future professionals in fields like criminology, sociology, and social work, and many women who started in settlement houses eventually went to posts in government.²² But one field has been overlooked within the settlement houses—that of nursing, which was then just developing as an independent profession with its own organizations and standards, and like many of the

Bureau. Jane Addams and Alice Hamilton, *My Friend, Julia Lathrop*, (New York: Macmillan, 1935).

²¹ Muncy, *Creating a Female Dominion in American Reform, 1890-1935*, xii.

²² Settlement workers often used their residency at settlement houses as an opportunity to investigate social problems and to report on social conditions. Woods, *The City Wilderness; a Settlement Study by Residents and Associates of the South End House; Hull-House Maps and Papers, a Presentation of Nationalities and Wages in a Congested District of Chicago, Together with Comments and Essays on Problems Growing Out of the Social Conditions*; Kellor and National Americanization Committee, *Neighborhood Americanization*.

other burgeoning professions, was dominated by women.²³ Most settlement workers were indeed part of the first generation of college women, and used that privilege to enter into new careers via the reform movement. But nurses did not attend seminaries or women's colleges to gain a liberal arts education; nurses were "trained" in what many considered a form of menial labor.²⁴ This perceived lack of professional and educational status has meant that historians of the Progressive era have ignored nursing as one of the paths to reform available to women.

But the settlement house movement did indeed provide the impetus for another professional sphere for women. Public health nursing, as created by Lillian Wald's Visiting Nurse Service, developed out of the Henry Street Settlement House, and went on to become a way for nurses to gain independence from doctors and to establish themselves in a specialized field, while still embodying the womanly qualities of the nurse.²⁵ Rather than being limited to

²³ As nursing historian Ellen D. Baer wrote, "The story of nursing, of course, is a study of gender." Ellen D. Baer, "'Do Trained Nurses ... Work for Love, or Do They Work for Money?'" *Nursing and Altruism in the Twenty-First Century*, *Nursing History Review* 17 (2009): 29. Nursing was considered more of an avocation than work, which made it difficult to establish professional authority. The history of nursing as a female profession with limited autonomy has been well written by Nancy Tomes, Susan Reverby, Barbara Melosh, and Darlene Clark Hine, among others: Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987); Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950*, *Blacks in the Diaspora* (Bloomington, Ind: Indiana University Press, 1989). Barbara Melosh and Susan Reverby, in particular, demonstrated the problem of nursing as a profession that required nurturing and service, qualities that were supposed to come naturally to women. "Nursing was to be... a woman's duty, not her job. Obligation to love, not the need of work, were to bind the nurse to her patient. Caring was to be an unpaid labor of love." Susan Reverby, "A Caring Dilemma: Womanhood and Nursing in Historical Perspective," *Nursing Research* 36, no. 1 (February 1987): 6.

²⁴ Nancy Tomes, "'Little World of Our Own': The Pennsylvania Hospital Training School for Nurses, 1895-1907," *Journal of the History of Medicine and Allied Sciences* XXXIII, no. 4 (1978): 507-30.

²⁵ Karen Buhler-Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore: Johns Hopkins University Press, 2001); Karen Buhler-Wilkerson,

working in a hospital or as private nurses in the homes of the wealthy—either by serving under the domain of male doctors or confined to private households—nurses sought to expand their roles and to advance their profession, and like other women professionals, they were gaining autonomy and beginning to occupy their own sphere within medicine.

This study demonstrates that public health nursing and reform were intertwined by a common women's culture. These groups of women succeeded in advancing their personal and professional lives by working in areas traditionally understood as the realm of women—health, reproduction, and household. If we examine closely the separate spheres of the nineteenth century, in which women were supposed to maintain the realm of the domestic and the private, we find that both nurses and reformers were expanding that boundary beyond the family. The maternalist policies of “urban housekeeping” and public health that these reformers promoted were maintaining the duties of women, while expanding the realm in which they performed them. This nudging of the private into the public sphere created professions for women outside the limits of marriage and family, but more importantly, created a space in which health could be considered a public issue.

In the fall of 1902, Lina Rogers of the Henry Street Visiting Nurses Settlement, at the request of the settlement founder Lillian Wald and the Health Commissioner of New York City Dr. Ernst Lederle, became the very first school nurse in the United States. She would pioneer the specialty of school nursing, and go on to create school nursing programs throughout the United States and Canada. Miss Rogers, as she was called, selected several schools on the Lower East Side, an area

False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930, Garland Studies in Historical Demography (New York: Garland, 1989).

with a great concentration of immigrants who lived in unhealthy tenements. Pupils came to school with a variety of maladies, from harmless head lice to blinding trachoma, as well as dangerous childhood diseases like measles or scarlet fever. Many also suffered from their poverty, resulting in malnutrition or anemia. Others had common problems such as poor vision, rotting teeth, or mental or physical disabilities.

Doctors had been performing medical inspections in New York City schools since 1897, examining children with the sole purpose of selecting those to be “excluded,” or sent home, if they showed signs of contagion. Inspectors did not make a definitive diagnosis and the children did not receive treatment. They left this to the parents, who were often unable or unwilling to pay for medical care to treat conditions that were not life threatening, or which were considered a normal part of childhood and thus requiring no special attention. The child could still be found playing in the streets, and if the problem did not go away on its own, he or she continued to be kept out of school indefinitely. At times, ten to twenty percent of the school’s population was excluded because of a disease or “defect.”²⁶

When Lina Rogers began working in the schools, she aimed not to send children home, but to keep them in class so they could continue learning. She performed a brief examination in the classrooms, much like the medical inspectors did, requiring students to line up and show their eyes, mouths, and hands. For the medical inspector, this was the end of the job; for the nurse, it was just the prelude. When the nurse had gotten a cursory look at all of the children, she would then exit the classroom and set up her dispensary, which at first was a couple of chairs next to a window sill, and call out individually those children whom she deemed in need of a more thorough examination. If the disease was considered highly infectious or dangerous, the child

²⁶ Lina Rogers Struthers, R.N., *The School Nurse* (New York and London: G.P. Putnam’s Sons, 1917), 16.

would be referred to the medical inspector and then sent home from school. But if the condition was minor and contagion could be controlled, the nurse treated the child then and there with the medical supplies at her disposal, then returned the pupil to the classroom.

Treatment of the child was one new step in the medical involvement of schools, but the nurse's most important job was to educate mothers about the maintenance of children's health. After school hours, the nurse visited several homes to teach mothers how to care for their children more thoroughly, and, in some cases, urged them to get additional medical treatment from a physician. Lina Rogers described her role as a school nurse as going well beyond the walls of the school. "The nurse," she wrote, "was interested in the child, the mother, the home, and she became the bond of friendship with the school."²⁷

The school nurse, then, was an important link between school and home, state and family. Her involvement with schoolchildren, through her service as their nurse, gave her an exclusive kind of access to both children and their mothers. The school was already an important point of intervention for immigrant children; nurses were also able to penetrate the homes of immigrant families in a way no other state agent could.

In this dissertation, I examine the context of the development of school nursing as an outgrowth of progressive reform; I look at school nurses as "progressive nurses" who were linked with the settlement house movement and wished to enact change through health care. I argue that the school nurse reflected the conviction of progressive reformers to transform the state's relationship to the family, to enlarge the responsibilities of schools to include a whole-child and

²⁷ Ibid., 8.

extended school approach, and to insist that the government take responsibility not just for the education of a child, but also for his or her overall well-being.

The progressive reformers I focus on—public health nurses like Lillian Wald and Lina Rogers, as well as other child health advocates like Dr. S. Josephine Baker—wanted to expand the government’s role in public health, especially in prenatal and maternal care. Although visiting nurses performed many of the same duties in the homes of families that school nurses later performed, the school nurse indicated a change in responsibility: while settlement houses were funded by benefactors, nurses and doctors in the schools were paid for by the city. Thanks to the efforts of progressive reformers, New York City became the first city in the world to place nurses under municipal control. Ultimately, progressive nurses believed that health, like education, should be in the realm of the government, and that once they had achieved the success of compulsory education, health care would be right around the corner.

I explore the various movements and strains of thought that come together in the Progressive Era to allow for the creation of school nursing as a vehicle for reform. The first, I argue, is the development of the Visiting Nurse Service of Henry Street Settlement, which provided health care in the homes of immigrant families on the Lower East Side beginning in 1893, and whose founder, Lillian Wald, is considered to be the world’s first public health nurse. Wald created a visiting nurses’ settlement because she believed that there was a link between the environment of the slum and the health of its inhabitants. As a nurse, she wished both to treat individuals and to alleviate the social conditions that contributed to their poor health. In the first chapter, I show how school nursing was an extension of her mission to provide healthcare to all families, and to extend that responsibility of healthcare into new realms.

In the next chapter, I discuss the exclusionary policy of the school medical inspection system in New York and compare it to that of Ellis Island immigration inspectors. I argue that the addition of nurses in schools reversed this policy and allowed children to stay in class, and thus created a “policy of inclusion” in both the schools and the body politic. In particular, Rogers and Wald felt that public education and universal health care for children were crucial for the development of democracy. For progressive nurses, education and health were the twin tenets of democracy, and one could not move forward without the other. Education was an essential right, but without healthy bodies, children would not be able to learn. The role of the school nurse embodied the belief of progressive nurses that both education and health care were fundamental necessities that should be provided by the state.

Chapter Three is about the role of school nurses in the lives of the children and families of the Lower East Side. I discuss an overlooked part of the history of school nursing, that of the home visit, and how this allowed for the nurse to be a crucial liaison between the state and the family. During these home visits nurses taught mothers how to properly treat the illnesses of their children, but also used the opportunity to teach about modern childcare and preventive health care practices. But the nurse herself was not the only means to reach the families; she also taught children to be health educators to their own parents by leading Little Mothers’ Clubs.

Finally, in the last chapter, I discuss the role of these reformers in creating the conversation about a national policy for children and health. I show that even though these reformers worked locally and drew their inspiration from the neighborhood, their ultimate goal was to use settlement projects as pilot programs that could be instituted on a broader level and brought to the nation. Throughout the book, there are traces about how these reformers thought about the role of the state in the lives of children, but this last chapter draws a firmer line

between settlement house projects and national programs. Furthermore, this chapter shows the resistance that reformers faced from the private sphere, particularly from the American Medical Association, in regards to their efforts to provide services to all children.

Chapter One

“We were to live in the neighborhood as nurses”:

Lillian Wald and the origins of public health nursing



A Short Cut Over the Roofs of the Tenements¹

“We were to live in the neighborhood as nurses, identify ourselves with it socially, and, in brief, contribute to it our citizenship. That plan contained in embryo all the extended and diversified social interests of our settlement group to-day.” Lillian Wald, *The House on Henry Street*²

¹ Jessie Tarbox Beals, *Visiting Nurse on Hester Street, Traveling over Rooftops*, 1908, Visiting Nurse Service of New York Records, 1889-2007. Health Sciences Library Archives and Special Collections, Columbia University Medical Center. Wald reproduced it in her own book with the caption given above. Lillian D. Wald, *The House on Henry Street* (New York: H. Holt and Company, 1915), 52–53. For this image and many other photos of Henry Street nurses throughout the century, see Ellen Paul Denker, *Healing at Home: Visiting Nurse Service of New York 1893-1993* (New York: Visiting Nurse Service of New York, 1993).

² Wald, *The House on Henry Street*, 8–9.

Lillian Wald pinned on the silver badge, her official insignia, and went to meet with her fellow nurse, Mary Brewster, before beginning the day's rounds. On this July morning in 1893, her first stop was to revisit the little Goldberg baby, whom she had been called to see the previous evening. Wearing her long dress and cap and carrying her heavy leather nurse's bag, she started while it was still cool, the sun just starting to heat up the New York streets. The Goldberg child was suffering from one of the number of childhood illnesses that made any baby's first year, especially the first summer, the most difficult to live through.³

A doctor had seen the baby the previous day and recommended treatments to the mother. But perhaps the mother, new to this country, did not understand his directions, or could not afford the medicines he had instructed her to buy. Like most doctors of the day, he would have kept his visit brisk and terse, and might have left the parents more confused and worried than before. When "Miss Wald" came later that evening, she was indeed a welcome sight. She and Miss Brewster were becoming known throughout the East Side as gentle and helpful. While softly cooing at the baby, and holding the worried mother's hand, the nurse asked the mother if she was breastfeeding, and if not, where she had purchased the milk she had given her child. Had it been properly kept on ice? What else had she been feeding her? Was the baby throwing up? Did she have diarrhea? How long had it been going on before she called the doctor? Miss Wald showed the mother how to nourish a dehydrated child, finding a kettle and putting it on the stove, boiling the water before giving it to the baby. She bathed the baby and changed its clothes, and instructed the mother to do this once a day, more often if the baby was soiled, and to wash and change the bedding frequently. Discreetly, she would have checked on the family's fuel supplies to make sure they had enough to follow through with her prescriptions. She stayed with the family for a while, doing some neglected household tasks and letting the mother have a moment to rest and care for her little one.

This morning, Miss Wald found the tiny patient improving, her pulse stronger. She bathed and fed the baby, providing some milk that she had picked up on her way there, and silently

³ This entire section is extrapolated from one document. Lillian D. Wald, "Report of a Day in the Life of A Visiting Nurse," July 25, 1893, Box 45, Folder 4, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library.

examined the baby and noted conditions, smiling and reassuring the mother. Since the enclosed tenement had a little more light this morning, she was able to take in the condition of the apartment and the other children, perhaps inquiring if the father was at work. A depression had hit the previous winter, and she might have found that he had lost his job and he was helping out the children with some piecework in the home; maybe he had been injured at work participating in some dangerous trade. Whatever the case, Miss Wald determined that this family was in financial straits, and called the doctor to let him know of their situation. Doctors were often not willing to do their work for free, even if it meant that some families went without care, so it may have taken some effort on the part of Miss Wald to convince him not to charge her patients. He conceded to waive the fee, and for her own services, Miss Wald did not ask for any payment. But she did tell Mrs. Goldberg she would be back to check on them later in the day.

The streets were busier now, and Wald was pushing past shoulders, veering around market carts and stepping over debris as she tried to reach her destination. She stopped by a vendor to purchase a bouquet of flowers, which along with her skirts and bag, she carried up the many flights of stairs to reach Hattie Isaacs, a young girl with consumption. Hattie turned out to be asleep, so Miss Wald cleared off the windowsill of the many empty medicine bottles, and placed the cheerful bouquet in their stead. When Hattie awoke, Wald warmed some water to give her a sponge bath, a task so arduous that it took Wald almost two hours to finish. The girl was probably covered in sores from spending so much time in bed, and Wald would have taken care not to cause her more pain. Afterwards, Hattie was carried to the couch so that the bed could be made with clean sheets and the blankets shaken out. Miss Wald did not give much instruction to the mother in this household, since Mrs. Isaacs knew what needed to be done and was very willing to do it; the girl was just so weak and frail that her mother required an experienced guide. Miss Wald had brought some fresh milk along with her, which she then mixed up with some egg for the girl, who could no longer feed herself at this stage in the illness. Giving the family a rest, Miss Wald took care of this task, and afterwards, warmly chatting with Hattie and Mrs. Isaacs, helped to straighten up the place before departing.

Wald next checked on some children at 11 Rutgers Street whose mother Miss Brewster had recently taken to the hospital. She probably found the boys playing in the streets avoiding the

apartment, by now quite hot, while daughters as young as six or seven were caring for babies out on the stoop. Perhaps the older girls fixed lunch, did laundry, or straightened the apartment in their mother's absence, chores they usually would have done by her side. Seeing children so young without any chance for real play, Miss Wald arranged for them to take an excursion to the seaside the following week. The children were probably very excited, since most boys and girls in their neighborhood, and many of the mothers as well, never left the few blocks nearest their homes.

On her way to 19 Hester Street, she stopped to inspect the tenements on the block. Looking in on the water closets, she noticed that they were in need of disinfecting, and she hunted down the housekeepers to put down some chloride of lime. Although the nurse's relationship with the Board of Health was at that time merely honorary, this is where the silver pin became useful; the official clout it implied frightened some landlords into following up on her recommendations. When she reached her destination, she did the usual rounds, asking if anyone needed attention. She heard some complaints about the water closets next door, but when she inspected them, found that they had recently been bleached and had plenty of water for flushing.

Elsewhere in the building, she treated a child with an ear infection, showing the toddler's mother how to do it herself, and gave her instructions on how to see a doctor for free at a local dispensary. She washed and changed babies, one who suffered from the "summer complaint," intestinal trouble that often dehydrated and killed infants in the warmer months. She gave the child bismuth to stop the diarrhea and offered an excursion ticket to get the children out of the sweltering city and into some fresh air for the day.

These were only her morning duties. She walked back to her apartment to wash up and have a brief lunch, repacking supplies in her bag: more fresh milk, extra ice tickets and excursion passes. She checked in to see if she had received any calls in her absence, and then she set out again, visiting more neighbors in need.

When Lillian Wald first entered this section of the city, the Lower East Side was the destination of many foreigners, especially Jews and Italians, who had emigrated from eastern and southern Europe.⁴ The living and working conditions of the neighborhood were notorious, and reformers and journalists were turning their attention to the social problems of the inhabitants of the slums. The Lower East Side was famous for its garment district, and many of the occupants, adults and children alike, were working long hours in close conditions.⁵ Reform-minded journalists revealed the neighborhood to be crowded, filthy, and dangerous. Jacob Riis' photographs in *How the Other Half Lives* (1890) made known conditions in the cramped tenements, and the hazards that both adults and children faced when they worked long hours in sweatshops for next to nothing.⁶ Photographs displayed dead horses in the streets, children without safe places to play, and tiny spaces of tenement apartments overfilled with families and their boarders. John Spargo's *The Bitter Cry of the Children* (1906) told of "the problem of poverty as it affects childhood," uncovering the high infant mortality rate and the fragile and sickly bodies of older children in the slums.⁷ He wrote of the "little mothers," the young girls who were left to care for the babies while their own mothers went to earn a wage; these were children who had no idea

⁴ Moses Rischin, *The Promised City: New York's Jews, 1870-1914* (Cambridge, Mass: Harvard University Press, 1977); John Higham, *Strangers in the Land: Patterns of American Nativism, 1860-1925* (New Brunswick, NJ: Rutgers University Press, 1992); John Higham, *Send These to Me: Jews and Other Immigrants in Urban America* (New York: Atheneum, 1975); Irving Howe, *World of Our Fathers* (New York: Simon and Schuster, 1983); Hasia R. Diner, *Lower East Side Memories: A Jewish Place in America* (Princeton: Princeton University Press, 2000); Elizabeth Ewen, *Immigrant Women in the Land of Dollars: Life and Culture on the Lower East Side, 1890-1925*, New Feminist Library (New York: Monthly Review Press, 1985).

⁵ Leon Stein, *Out of the Sweatshop: The Struggle for Industrial Democracy* (New York: Quadrangle/New York Times Book Co., 1977); Rose Cohen, *Out of the Shadow: A Russian Jewish Girlhood on the Lower East Side* (Cornell University Press, 1995).

⁶ Jacob A. Riis, *How the Other Half Lives: Authoritative Text, Contexts, Criticism*, A Norton Critical Edition (New York: W.W. Norton & Co, 2010).

⁷ John Spargo, *The Bitter Cry of the Children* (New York: Macmillan, 1906), xlii.

how to take care of themselves but had the delicate lives of infants left in their charge. Reformers were hoping to expose and thus transform the conditions in the neighborhood.

New York City was not alone with its problems of slums. Other cities were coming to terms with great numbers of impoverished immigrants trying to make their way in a new world, where increased urbanization and industrialization led to crowded areas in cities that were filled with unskilled, un-Americanized workers looking to find an income. The throngs of workers meant that factory owners could pay tiny wages to full-grown men, while justifying even less for women and children, all without the protection of child labor laws, fire safety codes or other health standards for workers, or the security of unemployment insurance or workmen's compensation if they fell sick or got injured on the job. Employers could demand fourteen-hour-days from workers, whatever their age or sex, without the intervention of any government agency.

Wald's Henry Street Visiting Nurse Service was inspired by these conditions, and was part of a broader impulse to enact change within neighborhoods. Settlement houses were springing up throughout the United States, and reformers moved to the slums both to help the inhabitants and to study the area to find solutions. The settlement house movement began in England, where Toynbee Hall in London served as an example to the young idealists who were looking for ways to put their own education to work. Established in 1884 by Samuel Barnett, Toynbee Hall brought together workers and young university men in a project to bring the social classes together. They lived in a poor neighborhood in London, and wanted the settlement house, as Allen F. Davis put it, "to make their settlement in the slums an outpost of education and

culture.”⁸ Toynbee Hall did not put as much emphasis on social reform as American settlement houses later did, and instead focused on the arts and building relationships between social classes.

Many young, college-educated men and women in the United States were also looking to put their training into action in some useful and practical way. Some settlement house founders were directly influenced by a visit to Toynbee Hall, but in many ways the American movement was an outgrowth of a similar impulse of Christian socialism in the face of Gilded Age wealth and the disturbing social change that resulted from increasing divisions between the rich and poor. The most famous of the American settlement houses was Hull House in Chicago, founded by Jane Addams in 1889, and its residents included Florence Kelley, Alice Hamilton, Julia Lathrop, and Edith and Grace Abbott.

Settlement house workers moved into the neighborhoods in which they worked, and became a part of it. Most settlement houses provided childcare, adult education classes, libraries, and workshops, as well as a space in the neighborhood for public use. The Lower East Side was no exception to the growing settlement house movement; when Wald arrived, one could already find the University Settlement (1891) and the College Settlement (1889) houses. Lillian Wald and her friend and fellow nurse Mary Brewster had just begun their small visiting nurse service in the summer of 1893, and were operating out of the College Settlement on Rivington Street until they could find an apartment to rent.⁹ By September they would have their own place on Jefferson Street, but for the summer they were among the many social-minded “residents” at the

⁸ Allen Freeman Davis, *Spearheads for Reform; the Social Settlements and the Progressive Movement, 1890-1914*, Reprint (New York: Rutgers University Press, 1984), 6–7.

⁹ Wald, *The House on Henry Street*, 10.

settlement, learning their way around the East Side from their comrades at the house. In 1895, Jacob Schiff purchased the property on Henry Street that would become their permanent home.

The underpinnings of progressive reform depended on some changes in the intellectual climate of the late nineteenth century emphasizing the environment over the individual, which was why living and working within the slums itself was considered such a crucial part of settlement house work. Previously, both science and religion blamed poverty, disease, and criminality on individuals rather than broader social forces. Most had believed that the poor lacked the moral character to defend against these afflictions, or possessed racial or genetic traits that destined them to a criminal or impoverished state.¹⁰ But many now rejected this view of society, and instead blamed the institutions that allowed such conditions to exist.

Progressive-era reformers, influenced by the social gospel, began to see the organic unity of the social body; they saw the interconnectedness between the many social problems that they were encountering. Reformers began to see health, food, pollution, poverty, and criminality as related to one another, and realized that to solve one problem, they might have to solve the next with it. Education was often seen as one step in the change to solve multiple problems, but only in combination with broader structural changes to the society and the environment.

Progressive-era reform was linked with new areas of university study that focused on environmental causes of social problems, such as academic fields like sociology and criminology. Many settlement houses were used as training grounds for research, which reformers believed was the first step to making improvements. Hull House, for example, had close ties to the University of Chicago, which was located nearby. The University of Chicago began its program in sociology in 1892, and many of the settlement house residents had earned

¹⁰ Suellen M. Hoy, *Chasing Dirt: The American Pursuit of Cleanliness* (New York: Oxford University Press, 1995), 101.

advanced degrees in the program. The slums of Chicago provided the perfect place for residents to do field research, to acquire accurate statistics, and to analyze social problems scientifically.¹¹

Most of these settlement houses were also filled with recent college graduates, and most of the female residents who participated were among the first generation of women to attend college. It was this environment of academic and social ferment that surrounded Lillian Wald when she began nursing, but her route to reform would be different from many others.

In the narrative Lillian Wald told about her introduction to life in the slums, she claimed that she was inspired to take action through her experience as a nurse, and it was her role as a nurse that shaped her vision in the years to come as she developed into a prominent social reformer. In 1893, Wald had already completed nursing school and was a student at the Woman's Medical College when she volunteered to teach a home nursing class on the East Side. Wald was in the middle of a lesson when a little girl came to ask for her help; her mother had recently had a baby and was very sick. The little girl led Lillian Wald over broken streets and smelly heaps of trash, pushing through crowds of people and finally climbing the "slimy steps" of a filthy, dark tenement to find the woman in bed, bloody from an untreated hemorrhage. This was what Wald called her "baptism of fire." She felt no contempt for the family and did not blame them for their condition, but rather felt a great sense of her own responsibility "as part of a society which permitted such conditions to exist." She was shocked by what she had seen, and in her naiveté

¹¹ Davis, *Spearheads for Reform; the Social Settlements and the Progressive Movement, 1890-1914*; Lela B. Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (Urbana: University of Illinois Press, 1983); Ellen F. Fitzpatrick, *Endless Crusade: Women Social Scientists and Progressive Reform* (New York: Oxford University Press, 1990).

believed that “conditions such as these were allowed because people did not *know*”; she thus felt challenged “to know and to tell.”¹²

For Wald, “all of the maladjustments of our social and economic relations seemed epitomized in this brief journey and what was found at the end of it.” Indeed, she did see an important connection between what she viewed on her “journey”—the filthy environment—and “what was found at the end of it”—a very sick woman in an unhealthy home. There could be no question that the health of the body and the health of the society were indeed related, and she felt that through her role as a nurse she would have a unique opportunity to improve that society. “I rejoiced that I had had a training in the care of the sick that in itself would give me an organic relationship to the neighborhood in which this awakening had come.”¹³

This belief in the “organic relationship” was one of the key features of the philosophy of Lillian Wald. She made a powerful connection between the environment and health, but more specifically, the neighborhood itself and the health of the bodies within it. Wald’s desire for organic unity was thus in line with other reformers who wanted to work alongside the poor, at least in the way they viewed the social body as a unified whole. But Wald also felt that she had a very literal connection to other bodies, in her view that sickness, like poverty and crime, was caused by social conditions, and that she had the power to help treat the causes of illness in individual bodies by working within the neighborhood and being closely connected to the needs of those living there.

A visiting nurse, as envisioned by Lillian Wald, was one who brought health care to the sick in their homes, and it was in this service that she and her friend moved to the East Side and went to work in the immediate neighborhood. This vision of nursing care would eventually

¹² Wald, *The House on Henry Street*, 8.

¹³ Ibid.

expand to become the Henry Street Settlement, with offerings as varied as English classes and a theatre program, but the project had much simpler beginnings than the institution it was later to become. Although the services of the Henry Street Settlement House were many, the agency that Lillian D. Wald began was first named the “Nurses’ Settlement” and supplied health care in the homes of families in the Lower East Side. The Henry Street Settlement shared many goals and programs with other settlement houses, but Lillian Wald’s first commitment was to nursing, and other additions to the settlement were driven by her belief that health could not be maintained without social reform.

Wald did not know it, but she was creating a new kind of service that expanded on a longer tradition of nursing in the home. There had been home nursing as part of charity organizations in the United States since the early nineteenth century, but they had an untrained nurse responding to a catastrophe or epidemic. One of the first associations in the United States to send out untrained nurses was the Ladies’ Benevolent Society of Charleston, S.C. Founded in 1813, it was formed as a response to a specific emergency, the epidemic of yellow fever that struck that year. The society chose a committee of sixteen to serve as visitors, and a nurse was called on when necessary and paid for and supervised by the lady visitors; it was disbanded after the Civil War.¹⁴

It wasn’t until many years later that organizations called Visiting Nurse Associations [VNAs] would send out trained nurses to “systematically care for the poor in their homes.”¹⁵ Most of the VNAs in the United States were modeled after the “district nursing system”

¹⁴ Annie M. Brainard, *The Evolution of Public Health Nursing*, Reprint (Originally published Philadelphia: Saunders, 1922), *The History of American Nursing* (New York: Garland Publishing, Inc, 1985), 189; Yssabella Waters, “The Rise, Progress and Extent of Visiting Nursing in the United States,” *Charities and the Commons* 16 (April 7, 1906): 16.

¹⁵ Brainard, *The Evolution of Public Health Nursing*, 191.

established in England in the 1860s and 1870s. William Rathbone, a Quaker philanthropist, was inspired by the care given to his wife by a private nurse, and he insisted that all people deserved the same quality nursing in their homes; he hired his wife's private nurse, Mrs. Mary Robbins, to treat the poor in Liverpool.¹⁶ In 1861, he called upon Florence Nightingale to aid him in expanding the program, and she wrote two very influential papers that garnered widespread support for their efforts. Especially convincing were her arguments about the “depauperizing” effects that the care of nurses had on the sick poor.¹⁷ Rathbone ran this nursing service the same way he organized other relief, district by district, with a “board of ladies” who supervised the work of the nurses, kept records, and distributed funds.¹⁸ By 1889, there was one standardized district nursing system for all of England. The first visiting nurse associations in the United States followed their model; they were connected with philanthropic entities, which usually had religious affiliations, and were directed by boards of managers.¹⁹

Visiting nurse and district nursing services existed in some large American cities since at least 1878, and some missionary societies had added a nurse to their service even before. In the appendix to Shawe's *Notes for Visiting Nurses* (1893), Mrs. Helen C. Jenks organized a “list of associations for the care of the sick not in hospitals” which included many major cities like New York, Boston, and Philadelphia, as well as smaller cities throughout the Northeast, and as far west as Kansas City, Missouri. Notably, not all of these were visiting nurse associations; often

¹⁶ Ibid., 107.

¹⁷ Karen Buhler-Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore: Johns Hopkins University Press, 2001), 18–21.

¹⁸ Ibid., 21.

¹⁹ Buhler-Wilkerson, *No Place Like Home*.

philanthropic or religious institutions added a nurse to their activities (and not always a trained one). Sometimes hospitals with training schools would lend out a nurse if they could spare her.²⁰

But some of these associations had conversionary motives and did not include health maintenance and education in their services. In 1877, The New York City Mission began sending out nurses,²¹ but according to early nursing historian Annie Brainard, their service was “more religious than scientific.”²² Brainard said that they could not be considered public health nurses because their work was “distinctly curative, not preventive” and they did not put in any effort to teach their patients about health. In 1879, the Society of Ethical Culture, under the direction of Felix Adler, began placing nurses in dispensaries. Adler was aware of the City Mission nurses, and Brainard noted that he felt that “the Mission regarded sickness merely as an opportunity to introduce religious teachings, and not primarily as an opportunity for public health work.”²³ He also thought that rather than nurses being sent without a doctor’s supervision, they should be attached to a dispensary and sent out for follow-up treatments for patients in their homes.

There are conflicting accounts about which American organization was first to send out trained nurses; Ysabella Waters gave credit to the Women’s Branch of the New York City Mission, while Annie Brainard bestowed the honor on the Nurse Society of Philadelphia because it was an independent organization.²⁴ In 1886, the Boston Instructive Visiting Nurse Association and the Visiting Nurse Society of Philadelphia were established, and shortly after, in 1889, the

²⁰ Rosalind Gillette Shawe, “Notes for Visiting Nurses (1893),” in *Nursing and the Public’s Health: An Anthology of Sources*, ed. Karen Buhler-Wilkerson (New York and London: Garland Publishing, Inc, 1989).

²¹ Waters, “The Rise, Progress and Extent of Visiting Nursing in the United States.”

²² Brainard, *The Evolution of Public Health Nursing*, 198.

²³ Ibid.

²⁴ Ibid., 191; Waters, “The Rise, Progress and Extent of Visiting Nursing in the United States,” 17.

Chicago Visiting Nurse Association began its work.²⁵ In any case, the deployment of trained nurses was becoming the norm for VNAs in the late nineteenth century, when the growth of hospital training schools changed the standard for nursing care and created a glut of trained nurses in the market.

There were other associations that were attached to dispensaries under the guidance of medical doctors. As early as the 1830s, two dispensaries in Philadelphia, the Lying-in and Nurse Charity, and the Lying-In Department of the Northern Dispensary, provided some regular nursing service. Beginning in the 1880s, the Instructive Visiting Nurse Service of the Boston Dispensary was added “to aid the dispensary’s district physicians in their work, not only nursing, but educating the poor in hygiene and diet.”²⁶ Doctors were still in charge of these dispensaries, and patients could only use them if sent by their physicians, who paid a subscription fee to support the dispensary and to gain referral privileges.

Although working under doctors limited the independence of nurses, the organizations that provided visiting nursing service in many ways paralleled the services and values of dispensaries. The nineteenth-century dispensary was a valuable institution that provided free medical service to the “worthy poor.” They were “free-standing and autonomous institutions” that depended on the participation of doctors, especially apprentices, as their main source of voluntary labor. They were an alternative to the hospital, which at the time was an unsavory place that people feared, and was usually the last resort of the dreadfully poor and downtrodden. The “undeserving poor”—“the prostitute, the drunkard, the lunatic and cripple”—were the city’s

²⁵ M. Louise Fitzpatrick, *The National Organization for Public Health Nursing, 1912-1952: Development of a Practice Field* (New York: National League for Nursing, 1975), 7.

²⁶ Rosenberg, Charles E., “Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary,” *Journal of the History of Medicine and Allied Sciences* 29, no. 1 (January 1974): 36–37.

responsibility and therefore went to hospitals, where they were treated more like “inmates than patients.”²⁷

Some dispensary doctors also did a form of home visiting, which they called “district visiting,” to treat patients who were too ill to get out and about.²⁸ Dispensaries tried to enforce an older requirement that doctors reside in the neighborhood in which they worked, which for doctors seemed unreasonable in the mid-nineteenth century slums, but became the standard for settlement house workers and some visiting nurse organizations. Finally, the doctors of the dispensaries also worked as “*de facto* social workers,” because they created links with other philanthropic agencies. Well aware that their medicines could only go so far when families went hungry or cold, dispensary doctors were becoming convinced that environmental and social conditions were critical to the health of the body, and created a network of services.²⁹

These two public health services—the dispensary and the visiting nurse association—overlapped only briefly. The dispensaries declined as the nineteenth century moved forward, not because they became unnecessary for the poor—in fact, there was an ever-growing need for low-cost medical care—but because they became unnecessary for doctors. In the early stages of the development of the medical profession, the dispensaries provided valuable training grounds for young, un-established doctors, and were often criticized because they employed unseasoned apprentices hoping to gain experience and skills. But as the hospital increased in prestige, and ambitious career men looked for a way up the ladder, hospital posts became far more desirable

²⁷ Ibid., 43. Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987), 2.

²⁸ Rosenberg, Charles E., “Rise and Fall of the Dispensary,” 33.

²⁹ Ibid., 36.

than work in a dispensary.³⁰ As the dispensary declined, visiting nurse associations flourished. By the end of the nineteenth century, work in public health was an increasingly low-status job for doctors, while becoming a prized career track for trained nurses.

The growth of visiting nursing was dependent on the changes in the professional status of nurses. Nurse training schools were a recent invention when Wald had attended. The first training schools were established in 1873, and were designed to use the Florence Nightingale model of nursing to reorder the hospitals. These training schools were meant to attract native, white women, and emphasized “womanliness” and character. It was a rigid, militaristic training that demanded order and obedience. Previously, nursing in hospitals was performed by untrained women of the lower classes and often involved more cleaning, washing, and watching than patient care; the new nursing schools tried to counter that image by accepting middle-class girls and insisting on “refined” behavior, which included separating themselves from other hospital workers, especially those who did domestic work. Although there was a general appeal to raise the level of the “quality” of nurses at this time, not all nursing students met the high standard desired.³¹

In the 1880s, when hospitals realized the student nurses could be an abundant source of cheap labor, there was rapid growth in the number of training schools attached to hospitals and there was very little consistency in quality or methods.³² But a new profession for women had opened up just in time for Lillian Wald to take advantage of it.

³⁰ Rosenberg, Charles E., “Rise and Fall of the Dispensary”; Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (New York: Basic Books, 1987); Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

³¹ Reverby, *Ordered to Care*; Barbara Melosh, *The Physician’s Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 30–31.

³² Reverby, *Ordered to Care*, 3.

Lillian D. Wald was born in Cincinnati on March 10, 1867, but spent most of her young life in Rochester, New York, where her father worked in the sales of optical supplies and kept the family among the moderately wealthy.³³ She was born to Polish-German-Jewish immigrants: her parents, Minnie and Max D. Wald, had come to the United States after the political uprising of 1848 that had brought a brief moment of hope for civic equality before sputtering out and exposing Jews and other vulnerable communities to further persecution.³⁴ Although there was no

³³ Information about Wald's biography can be gained from various sources. Wald wrote two books about her experiences at the Henry Street Settlement. She did not call them memoirs, and indeed the insertions of her own story are minimal, but instead she focused on the various aspects of the work at the settlement; however, we get a very good sense of Wald's commitment and philosophy behind her work through her descriptions of the people of the neighborhood and their needs. Wald, *The House on Henry Street*; Lillian D. Wald, *Windows on Henry Street* (Boston: Little, Brown, and Company, 1934). R.L. Duffus wrote a biography of Wald during her lifetime with her approval and collaboration. The result is informative, but mostly laudatory. R. L. Duffus, *Lillian Wald, Neighbor and Crusader* (New York: The Macmillan company, 1939). Beatrice Siegel's approach as an independent historian and biographer reveals an interest in different sources that are not mentioned elsewhere, and thus has remarkable insight especially into Wald's early life. Siegel included the oral histories held at Columbia University, as well as her own interviews with the last surviving visitors at the settlement. Above all, Siegel's attention to detail put Wald in context and brings her to life. Beatrice Siegel, *Lillian Wald of Henry Street* (New York; London: Macmillan ; Collier Macmillan, 1983). Marjorie N. Feld, *Lillian Wald: A Biography* (Chapel Hill: University of North Carolina Press, 2008); Feld's biography looks at Lillian Wald through the lens of her Jewish identity and described her as an "ethnic progressive." Wald would have rejected an understanding of herself that focused on her heritage, but Feld argued one must still keep her Jewishness in mind, and explore how ethnicity and gender interact. "Though Wald herself may have bristled at the label, it alerts modern readers to the important ways in which Wald's ethnic background *and* the women's political culture she joined combined to shape her identity." Feld is particularly critiquing Doris Groshen Daniels, who instead took Wald at her word and considered her Jewishness to be unimportant, and focused instead on gender. Daniels argued that Wald's role as a social reformer was always wrapped up in her desire to elevate the status of women. Daniels argued against other historians like J. Stanley Lemons who had called her a "social feminist" whose feminism was subordinated to social causes. Doris Groshen Daniels, *Always a Sister: The Feminism of Lillian D. Wald* (New York: The Feminist Press at the City University of New York, 1989).

³⁴ Cecil Roth, *A History of the Jews: From Earliest Times through the Six Day War*, Rev. ed. (New York: Schocken Books, 1989), 330.

systematic philanthropy in the household, her mother was known to be enormously generous to individuals in need.³⁵

Lillian Wald did not attend a women's college, unlike many other reformers. Lillian was sent to private school at Miss Cruttenden's English-French Boarding and Day School for Young Ladies and Little Girls in Rochester.³⁶ "I must say that I have had advantages of what might be called a good education," Wald wrote a few years later.³⁷ There she learned Latin, French, and German. At 16, she applied to Vassar, but they turned her down, ostensibly because of her age, and although she was encouraged to apply again later, she never did. On a visit to her married sister Julia Barry, Wald met a trained nurse, a Bellevue graduate, who was there to assist during Julia's childbirth. From her, Wald was able to find out about the life of a graduate nurse and the demands of the hospital training course. She quickly followed up on her own decision to pursue this career, and applied to the nurses' training school at New York Hospital. "I had little more than an inspiration to be of use in some way or somehow, and going to the hospital seemed the readiest means of realizing my desire," she said in 1915, echoing the same sentiment that other young women expressed about their inactivity after years of education.³⁸

³⁵ Duffus, *Lillian Wald, Neighbor and Crusader*.

³⁶ Clare Coss, ed., *Lillian Wald: Progressive Activist* (New York: Feminist Press at the City University of New York, 1989), 3.

³⁷ Wald, Lillian D., "Application Letter to New York Hospital School of Nursing," May 27, 1889, Box 1, Lillian Wald File, Cornell University-New York Hospital School of Nursing, Student Records, 1878-1975 (Medical Center Archives of New York-Presbyterian/Weill Cornell, New York, NY). A copy can also be found in Lillian D. Wald, "Application Letter to New York Hospital School of Nursing," May 27, 1889, Box 2, Folder 1, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library.

³⁸ Wald, *The House on Henry Street*, 1; Jane Addams, *Twenty Years at Hull-House* (Signet Classics, 1999); Christopher Lasch, "Jane Addams: The College Woman and the Family Claim," in *The New Radicalism in America, 1889-1963* (New York: W. W. Norton & Company, Inc., 1965), 3-37; Allen Freeman Davis, *American Heroine: The Life and Legend of Jane Addams* (Chicago, IL: Ivan Dee, 2000). Lasch discussed Jane Addams' sense of "her own uselessness" and described her essay "The Subjective Necessity of Social Settlements" as "in the form of a

In Wald's application letter, one can hear a bit of the boredom about her young lady's training in language, manners, and household, especially in the interval since the completion of her studies. "My life hitherto has been—I presume—a type of modern American young womanhood, days devoted to society, study and housekeeping duties such as practical mothers consider essential to a daughter's education." It was clear in this letter that she was ready to move on, and use her quality education for something beyond courtship, family, and society. "This does not satisfy me now, I feel the need of serious, definite work. A need perhaps more apparent since the desire to become a professional nurse has had birth. I choose this profession because I feel a natural aptitude for it and because it has for years appeared to me womanly, congenial work, work that I love and which I think I could do well."³⁹ Wald was admitted to the training school in August of 1889 at the age of 22. In her letter of support, Miss Cruttenden described Lillian as a woman with "fine qualities ... intelligence, amiability, high principles, and excitement." Wald was thus considered an ideal candidate for these new hospital training schools.

Wald never gave much detail about her time in nursing school, but to say that they were "strenuous years for an undisciplined, untrained girl, but a wonderful human experience." It also did not allow for time to think about the world outside the walls of the institution, and she "saw little of life save as it flowed into the hospital wards."⁴⁰ She spent two years at the hospital before moving on to work in the Juvenile Asylum, where she was completely appalled at the

general analysis of the problem facing young girls in her class." That said, Lasch considered the rejection of the "family claim" as the primary motivation for Addams' reform. Allen F. Davis took more seriously the languishing of young women after this first generation of college women returned home from their studies, and noted that not just Addams, but many of her fellow graduates with whom she corresponded expressed very similar sentiments of despondency and lack of a sense of purpose.

³⁹ Wald, Lillian D., "Application Letter to New York Hospital School of Nursing."

⁴⁰ Wald, *The House on Henry Street*, 1.

treatment of the children there, and became set against the institutionalization of children in general. After this disappointment in her first job as a trained nurse in an independent position, Wald decided to move on. With the intention of becoming a doctor, she started taking classes at the Woman's Medical College before she was drawn to the East Side.

It was then that she volunteered to teach the home nursing class for immigrant women that would change her life forever. When Minnie D. Louis, who had organized the program, learned of Wald's continuing interest in providing nursing service to the poor in the neighborhood, she introduced her to Mrs. Solomon (Betty) Loeb and her son-in-law Jacob Schiff to become possible funders.⁴¹ Loeb was so impressed by Wald's enthusiasm and idealism that she was unsure if the nurse was "crazy or a great genius."⁴² Deciding that matter with her pocketbook, Loeb agreed to support her. She and Schiff would become the primary benefactors for the initial service, each providing the salary for a single nurse, and Schiff would continue to support it throughout his lifetime. Wald abandoned her plan to become a doctor and devoted herself to nursing the poor.

Schiff was a wealthy banker and an established Jewish philanthropist when he encountered Wald, and as he did with all of his other relief projects, he required careful financial reporting.⁴³

⁴¹ Coss, *Lillian Wald: Progressive Activist*, 4; Feld, *Lillian Wald*, 213 n. 59. Duffus wrote that Betty Loeb organized the home nursing class, but Feld located a letter from Schiff to Wald that described Minnie Louis introducing Wald and Loeb.

⁴² "Rita Wallach Morgenthau Radio Talk," October 15, 1953, Reel 1 Box 1, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library; Karen Buhler-Wilkerson, "Lillian Wald and the Invention of Public Health Nursing," in *No Place Like Home* (Baltimore: Johns Hopkins University Press, 2001), 100; Duffus, *Lillian Wald, Neighbor and Crusader*, 36; Siegel, *Lillian Wald of Henry Street*, 28.

⁴³ Naomi Wiener Cohen, *Jacob H. Schiff: A Study in American Jewish Leadership*, Brandeis Series in American Jewish History, Culture, and Life (Hanover, NH: Brandeis University Press, 1999).

Although Wald's first accounts are ostensibly for monetary oversight, she seems, more importantly, to be recording the miseries of the city and demonstrating the need for her services. In August of 1893, shortly after her arrival in the East Side, Wald wrote to Schiff to tell him the effect of the Depression that had hit the previous winter, and the distress it had caused to those in the neighborhood. She made particular mention of men who in better times had been able and willing to work. Wald was particularly struck by the downfalls of these folk, because their pride would not allow them to accept aid, which left them "virtually starving." The situation became so dire that Wald had requested that the *Herald*—the newspaper that provided the ice tickets that Wald frequently distributed to keep food and milk fresh—instead provide bread tickets because "there was nothing to put on the ice."⁴⁴ It is unclear from this letter whether or not the *Herald* agreed, but the *World* was doing so, "but in a rather demoralizing fashion," which could not have helped those already too ashamed to accept aid. Wald also mentioned how this misery was not rare, but rather seemed to be spreading to those who had not been affected by this kind of poverty in the past. To Schiff she remarked, "All these particulars, you as a philanthropist, are of course acquainted with and are not particular to the present depression—it is only that one may say, that the tales are general and not at all particular that must be peculiar."⁴⁵

Although Wald was beholden to Jacob Schiff as her primary benefactor, she was given daily freedom in how she could distribute funds. Schiff kept a careful eye on her spending, but she was allowed to make her own decisions regarding the disbursements and justify them later in her reports. At first he required weekly accounts, and after a day out treating patients Wald would dutifully log her activities by lamplight. Her first letters were so incredibly detailed, and

⁴⁴ Lillian D. Wald, "Report to Jacob Schiff in August of 1893," August 29, 1893, Box 2, Folder 1, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library.

⁴⁵ Ibid.

her days so full, that it is surprising that she had any time to write them at all. In her July 7, 1893, letter, both nurses met separate patients at 7 pm: one nurse met a doctor at a family home and made arrangements for a hospital stay; the other nurse got a patient settled in for the night with food and bedding, and even flowers. Wald detailed the multiple visits the nurses made each day and commented on the needs of each patient. And it was exhausting indeed. Wald remarked in a report the following summer that the nurses sent over from Mount Sinai cracked under the pressure, the first leaving after just a few days. The second left as well, and only on the third try did they obtain a nurse who was able to stay it out.⁴⁶ Over time, Wald switched to monthly reports, and although they too are filled with details, Wald even seems a bit exasperated by the need to tell about each activity of the settlement. “P.S. Of course it is understood that these monthly reports merely report a few of the things done. In fact we have been so busy the past month that very little written record of the work beyond addresses has been impossible.”⁴⁷

After a while, Schiff lightened the load even further. In 1909 he wrote, “Indeed there is no necessity for sending me on New Year an account of your activities during the year. You and the ladies associated with you are constant living accounts of your value, not only to the community, but to mankind in general, and my only wish is that you may remain long undiminished in health and strength, but also that you are so much needed, that you do not overtax yourself, which I am afraid you do from time to time.”⁴⁸

The admiration and affection between Schiff and Wald were palpable in the letters, and it was clear that Schiff trusted Wald to make good decisions. There were times that Wald requested

⁴⁶ Ibid.

⁴⁷ Lillian D. Wald, “Report to Jacob Schiff,” November 3, 1893, Box 2, Folder 1, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library.

⁴⁸ Jacob H. Schiff, “Letter to Lillian Wald,” January 5, 1909, Reel 8, Folder 57, Lillian D. Wald Papers, Rare Book and Manuscript Library, Columbia University.

the opinion of Schiff on moneymaking decisions and acted against his suggestion; there were times that Schiff exerted his authority and adamantly denied Wald a particular request. For example, Schiff thought it was a bad idea for the settlement to incorporate, and thought it was a better idea to keep the settlement more “like a family.” The Settlement did incorporate all the same. But Schiff made it very clear that Wald had no right to go into debt against the Henry Street building in order to expand the settlement, and was unequivocal that she could not do so.

Wald came from a German-Jewish background, but her nursing service was not strictly for the Jewish community, although that was the population it served most often. Indeed, the Jewish population was most in need, since the East Side was made up mostly of Russian Jews escaping persecution in Europe. Furthermore, Jews were likely to be targeted by Christian organizations and required to make religious concessions to receive aid. Rose Cohen, a Jewish Russian girl in the East Side who spent time at the settlement and was nursed by Lillian Wald, recounted in her memoir the distress of her mother when her hungry younger brothers and sisters went to a school run by a Christian missionary society and “any child in the class who would say a prayer received a slice of bread and honey.”⁴⁹ Jacob Schiff was particularly sensitive to the “missionizing” of Jewish immigrants by Christians, and supported the Hebrew Free School Association, which was designed to “counteract the conversionary efforts of the free Christian mission schools.”⁵⁰

The missionary presence in the Lower East Side was so marked that Wald had to battle the misconception that she might be working for a sectarian group. She was careful to go out in

⁴⁹ Cohen, *Out of the Shadow*, 160. Although there are many memoirs of immigrant children growing up on the East Side, this is the only one I have located that detailed an interaction with the Henry Street Visiting Nurse Service.

⁵⁰ Cohen, *Jacob H. Schiff*, 48.

her nurse's uniform with her bag, so that she would be recognized as a nurse in the community, and gain the familiarity and respect of other residents. Wald proudly quoted one immigrant's description of the Henry Street nurses as "sisters without religion."⁵¹ Her badge from the city, which she feared she had requested rather "presumptuously," not only gave her some official prestige, but since it said "under the auspices of the Board of Health," she hoped it would also make clear that she was not part of any particular group or mission.

Since they had no experience, Wald and Brewster adhered to a very basic principle regarding the kind of service they wished to create: "We tried to imagine how loved ones for whom we might be solicitous would react were they in the place of the patients whom we hoped to serve."⁵² In doing so, Wald and Brewster were acknowledging a commonality between their poorer patients and themselves. They should be treated, Wald and Brewster agreed, as they would like their own family members to be treated. The poor did not deserve lesser care because they could not pay for it, and they did not deserve to be humiliated for receiving it.

Most visiting nurses were associated with charity, which made patients reluctant to call on them at first. Wald and Brewster made sure to charge a token fee of ten cents that could be waived if necessary, so that neighbors would feel no shame to call on them, and therefore would not wait until a moment of absolute desperation to do so.⁵³ This payment was only a small part of the real cost of the services that the nurses provided, but even these fees could be a large percentage of a worker's wages and family income.

One could understand this reluctance to call upon charity, especially if we compare Wald's attitude to some of those charity providers who focused on individual responsibility and

⁵¹ Wald, *Windows on Henry Street*, 102.

⁵² Wald, *The House on Henry Street*, 26.

⁵³ *Ibid.*, 28–29.

wanted the poor to feel ashamed for their own need. For example, Josephine Shaw Lowell, director of the Charity Organization Society of New York, called the needy “idlers,” and said they lived in poverty as a result of their own lack of character. She believed that inducing personal reform was a crucial part of charity work and was always searching for the “moral flaws that underlay such conditions.” When sending out aid workers to unemployed families, she would encourage them to put the head of household to work chopping wood or scrubbing floors, “anything to avoid the dreadful lesson that it is easy to get a day’s living without working for it.”⁵⁴ Wald did not want to be associated with this humiliating form of charity, and recognizing the environmental rather than moral nature of poverty, gave her patients a feeling of control over the services they received from the nurses. As Wald put it, “we planned to create a service on terms most considerate of the dignity and independence of the patients.”⁵⁵

Lillian Wald and Mary Brewster named their visiting nursing service after the street where it was located, not its donor, signaling the commitment to the neighborhood itself as its inspiration. Wald and Brewster left their first home on Jefferson Street in 1895 to establish themselves in the building located at 265 Henry Street. “Henry Street then as now was the center of a dense industrial population,” Lillian Wald wrote to describe her new home.⁵⁶ It would also become the center of an expanding settlement house that would extend to all of the boroughs, and even annex the building where Wald gave her first home nursing class. But Henry Street Settlement House was not only integrated in the neighborhood around it; the residents inside also built their own communities and networks within.

⁵⁴ Hoy, *Chasing Dirt*, 101.

⁵⁵ Wald, *The House on Henry Street*, 27.

⁵⁶ *Ibid.*, 3.

The Henry Street Settlement House was a world in which women were freed from domestic duties and family obligations, and in which women were supported and maintained by other women.⁵⁷ The settlement house had a few core residents, and they called themselves “the family.” They spent both their work and leisure time among members of the family. “They worked together on all projects, lived and vacationed together for over 50 years, and, often in company with the women of Hull House, travelled together to Europe, Japan, Mexico, and the West Indies.”⁵⁸

Lillian Wald is often listed alongside Jane Addams of Hull House as one of the most famous settlement workers, but their paths to social reform were not parallel. Jane Addams began her memoir *Twenty Years at Hull-House* with her early life, “on the theory that our genuine impulses may be connected with our childish experiences.”⁵⁹ Addams credited her middle-class upbringing in rural Illinois and the religious education begun by her Quaker father for her later activities at the settlement house. Addams was also one of the first generation of

⁵⁷ For a focus on Henry Street’s all-women’s environment, see especially chapter five, “A Women’s World” in Daniels, *Always a Sister: The Feminism of Lillian D. Wald*; Blanche Wiesen Cook, “Female Support Networks and Political Activism: Lillian Wald, Crystal Eastman, Emma Goldman,” *Chrysalis*, no. 3 (1977). For women’s “homosocial world,” see Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (New York: Oxford University Press, 1985). Other works on women’s political culture, Estelle Freedman, “Separatism as Strategy: Female Institution Building and American Feminism, 1870-1930,” *Feminist Studies* 5 (Fall 1979); Kathryn Kish Sklar, “Hull House in the 1890s: A Community of Women Reformers,” *Signs* 10, no. 4 (Summer 1985): 658–677. For a discussion of the community-building that happened at women’s colleges, see: Barbara Miller Solomon, *In the Company of Educated Women: A History of Women and Higher Education in America* (New Haven; London: Yale University Press, 1985); Carol Lasser, “‘Let Us Be Sisters Forever’: The Sororal Model of Nineteenth-Century Female Friendship,” *Signs* 14, no. 1 (October 1, 1988): 158–181.

⁵⁸ Cook, “Female Support Networks and Political Activism,” 49. This important article explored not only the social and professional networks that women created to break away from the obligations of the “family pull,” it was the first article to seriously examine the romantic lives of social reformers like Lillian Wald, who Cook argued had a series of lesbian relationships.

⁵⁹ Addams, *Twenty Years at Hull-House*.

college-educated women who would have the experience of education without any professional opportunities or outlets for their knowledge and skills. By the time she graduated from Rockford Seminary, she had already decided that she would “live with the poor.” She would later tour Europe and learn of Toynbee House and the settlement house movement in England, and would be both inspired and saddened that her education had not prepared her to deal with the reality of social inequality.

Addams was not afraid to ponder her own motivations for her involvement in Hull House, nor did she hesitate to admit her own personal benefit. In “The Subjective Necessity of Social Settlements” she expressed why social work was as beneficial to the reformers as it was to the clients whom they served. Her generation, she argued, suffered from “fatal want of harmony between their theory and their lives, a lack of coordination between thought and action.” They needed to apply their ideas to some purpose, to put their education to use. These young people had heard and read of “human brotherhood” and of the “democratic ideal,” but they did not have the opportunity to act upon it. Educated women, in particular, should not have their ambitions quelled, and Addams did not understand why women with training should be left useless for “want of a proper outlet for active faculties.” She was speaking for many of this generation of college-educated women when she said that it was damaging to “health and to life itself” to sit idly; a young woman “does not understand this apparent waste of herself, this elaborate preparation, if no work is provided for her.”⁶⁰ But women reformers did manage to carve out a realm of professionalism from within settlement houses and build upon networks they formed in their women’s colleges.

⁶⁰ Ibid., 77.

Addams could at times be very abstract, and much of her social work was inspired by a need to put theory into action. Her memoir was imbued with the language of the social gospel, and the desire to put the words of Christ to work. She had felt a moral calling, and her visit to Toynbee gave her a model for how to answer it. Although Wald's biographers would note her childhood among giving and socially conscious parents, Wald did not mention her family or upbringing in her story of Henry Street, and never admitted to any early-life awareness of social inequality. When she discussed her nursing education, it was only to note its limits: the frantic pace of training and the narrow focus of studies were her excuse for her lack of knowledge about the world around her, and an explanation for her shock when she first encountered the East Side.⁶¹

Wald was probably familiar with some reform ideas, which might have been what led her to the East Side in the first place. She had attended the International Conference of Charities, Corrections, and Philanthropy at the 1893 Chicago World's Fair, where she would have met many prominent reformers from both sides of the Atlantic, and heard papers by other nurses. But even if facts may tell us that Wald had some introduction to reform ideas before she began her settlement, she did not ground the justification for her work in theory, nor did she argue that ideas propelled her to action. Throughout her memoir, Wald maintained that all of the settlement activities were inspired by her experiences in the neighborhood, starting with her first climb up those tenement steps that led her to start a nursing service. She often included accounts of the individuals she met who convinced her of the necessity for certain projects. For Wald, a good idea was never expressed in the abstract; it was rooted in the needs of individuals within the neighborhood.

⁶¹ Wald, *The House on Henry Street*, 2.

Evidence contradicts Wald's claims of spontaneity and neighborhood inspiration, and she might even seem arrogant to claim to have come up with these ideas on her own. But on the rhetorical level, grounding all of her actions in experiences within the neighborhood remained consistent with her grass-roots philosophy for the settlement and the visiting nurse service. She always maintained the message that she was working from within the neighborhood, rather than bringing theories from outside and transplanting them to the East Side. In all of her writings, Wald emphasized that the settlement activities were a response to the needs of her neighbors and that the flexibility of the social settlement to those needs was its greatest strength.

This commitment to neighbors, the neighborhood, and the community was what Wald deemed so different about her nursing service. It was a response to patient needs, tearing away all the red tape that charities demanded, but it also gave her patients greater dignity as peers and as agents in their own improvement. Wald did not claim to alter the way nursing itself was practiced among the poorer classes, but rather proffered a different philosophy among the nurses and a more reciprocal relationship with the patients. Her service was not managed from without, and her funds were not disbursed from a board that would have kept her under their management. Wald emphasized the spirit of community, and considered that aspect to be what distinguished her system from other kinds of district nursing. "We conceive the underlying thought of the district nurse to be that of neighborliness and plan to have each nurse work in a small district in close touch with the settlement house that she belongs to, that recourse may be had to it in emergency as quickly as possible."⁶² Wald worked from within the neighborhood, and treated her patients like neighbors.

⁶² Lillian D Wald, "The Nurses' Settlement," in *Third International Congress of Nurses* (presented at the Third International Congress of Nurses: Pan-American Exposition, Buffalo, September 18, 19, 20, 21, 1901, Cleveland, Ohio: Press of J.B. Savage, 1901), 261–271.

The settlement house was not a bureaucratic institution in which women might live separately and “go to the office” for meetings and task delegation. Their private lives were intertwined with their reform work. For the most part, living as a single woman was not a socially acceptable option for most young women of their day, and the woman-centered community of the settlement house was an improvement over the kind of family obligations they would have been expected to fulfill.⁶³ As Blanche Wiesen Cook has written, “The vigor and strength of these ... women, born daughters in a society that reared daughters to be dependent and servile, cannot be explained without an understanding of their support networks and the nature of their private lives. Their lifestyles varied as dramatically as did their public activities from the prescribed norm of ‘wife-mother in obedient service to husband-father’ that their culture and their era valued above all.”⁶⁴

Each morning the women gathered for breakfast and read the mail out loud.⁶⁵ I like to imagine them with their coffee, sitting around the table, interjecting comments, laughing out loud or perhaps getting heated with rage. It must have been an inspiring way to start the morning, and indeed, many great ideas emerged from this gathering spot. It was here, for example, that the

⁶³ Cook, “Female Support Networks and Political Activism”; Estelle Freedman, “Separatism as Strategy: Female Institution Building and American Feminism, 1870-1930.” The core set of women at Henry Street Settlement referred to themselves as “the family.” Lina Rogers Struthers, early resident long parted from New York City and married in Toronto, would write back a decade later and call the settlement “home.”

⁶⁴ Cook, “Female Support Networks and Political Activism,” 45.

⁶⁵ Dock, Lavinia, “Letter to Lillian D. Wald (Florence, Italy),” December 26, 1903, Reel 3, Folder 8, Lillian D. Wald Papers, Rare Book and Manuscript Library, Columbia University. There are a few mentions of this kind of group letter reading, but one of the ways that I know that it was the general habit of the group to read letters aloud at the table was that Lavinia Dock specified to Lillian Wald if a letter was not supposed to be read aloud to “the family,” that it was for her eyes only. “Dearest Lady, This is not entirely private but has some private thing in it so don’t read it aloud to the assembled clan.”

idea for the Federal Children's Bureau first started. Reading the newspaper in 1903, someone came across the fact that the federal government was alarmed enough at a boll weevil plague in the south to send agents there to study and solve the crisis. The residents were outraged by this expensive campaign to save cotton, while 300,000 babies died a year without response. And suddenly they'd hatched the idea for an agency devoted to the welfare of children, which they brought to fruition in 1912.⁶⁶

Perhaps it was because of this table-talk atmosphere that Lillian Wald feared that any biographer would overstate her own involvement in all of these projects, and miss the more cooperative thinking and acting. Lavinia Dock wrote this description of life at Henry Street in 1898 that showed the autonomous yet cooperative atmosphere. "Let me try to outline the daily round in Henry Street," said Miss Dock.

Breakfast is at half past seven, and unless guests are staying in the house this is often the only meal at which the members of the family find themselves alone together. The postman comes; letters are opened and read, work and plans for the day are talked over and arranged. Afterwards the rooms are set in order; new cases that have come in are distributed by the head of the family, and the nurses go off on their rounds. The entire day is spent in caring for the sick, and in following out the different lines of work which develop from this, the primary one. The nursing is of course much like the work of district nurses in general, except for the entire absence of any kind of restrictive regulation. Each nurse manages her patients and arranges her time according to her best judgment, and all points of interest, knotty problems, and difficult situations are talked over and settled in family council. The calls usually came from the people themselves, through charitable agencies, clergymen and physicians furnish a percentage. Often the nurse is sent for before a doctor is called, and then, if one is needed, she decides whether to apply at the dispensary, or to submit the patient's case to one of the best uptown specialists, or to advise hospital care.⁶⁷

⁶⁶ Wald, *The House on Henry Street*, 164; Lillian D. Wald, "The Idea of the Federal Children's Bureau," in *Readings in the Development of Settlement Work*, ed. Lorene M. Pacey (New York, 1950), 222–225.

⁶⁷ Duffus, *Lillian Wald, Neighbor and Crusader*, 63–64.

There were many nursing pioneers living at the settlement house within a short time of its establishment. Although fellow founding member Mary Brewster left Henry Street, a number of other capable nurse-residents joined Wald: Lavinia L. Dock, Adelaide Nutting, Annie Goodrich, Lina Rogers, and Ysabella Waters, among others. The “laity,” as they called the non-nurses, were women like Helen McDowall (Tante Helen) and Florence Kelley.⁶⁸ They called each other by endearing nicknames, a continuation of a practice likely established while in nursing school.⁶⁹ Lavinia Dock was called “Docky,” a name she took on affectionately, and she often signed her letters with the name.⁷⁰

Wald had met Lavinia Dock in Chicago in 1893, while both were in town for separate conferences held in conjunction with the Columbian Exposition. Wald attended the conference on Charities and Corrections, and Dock gave a featured address at a conference on hospitals organized by Johns Hopkins University, where she spoke on the necessity of separate spheres of authority for nursing and medicine in hospitals.

Dock had already begun an illustrious career in nursing and reform when she met Wald. She had graduated from Bellevue Hospital Training School for Nurses in 1886, and by 1890 she had published *Materia Medica for Nurses*, a drug manual that she compiled while serving as

⁶⁸ Coss, *Lillian Wald: Progressive Activist*, 5.

⁶⁹ Melosh, *The Physician's Hand*, 114.

⁷⁰ See note above about the discussion of all-women's communities. But for an extension of that understanding and the family-replacement that was built in nursing schools, see: Nancy Tomes, “‘Little World of Our Own’: The Pennsylvania Hospital Training School for Nurses, 1895–1907,” *Journal of the History of Medicine and Allied Sciences* XXXIII, no. 4 (1978): 507–530; Douglas O. Baldwin, “Discipline, Obedience, and Female Support Groups: Mona Wilson at the Johns Hopkins Hospital School of Nursing, 1915–1918,” in *Enduring Issues in American Nursing*, ed. Baer, Ellen D. et al. (New York: Springer Publishing Company, 2001), 85–105. According to Baldwin, Mona Wilson called her fellow nursing students “the family” and they all took on adopted nicknames. I suspect that Dock, Wald, and the other nurses moved many of their all-female community traditions from nursing school into the women's world of the settlement house, just as the college-educated women of Hull House did.

night superintendent at Bellevue and that “became the standard nursing school text for a generation.”⁷¹ She also became nursing’s historian, and in 1907 the multi-volume *History of Nursing* was released, the first of many editions.⁷² Most nurses would recognize her work as a contributing editor to *The American Journal of Nursing*, the official organ of the American Nurses Association. In her efforts to unify and professionalize nursing across the world, she traveled to many countries to establish contacts and promote the profession. In late 1896, Dock moved to Henry Street Settlement and was one of Wald’s closest compatriots.⁷³

Dock was also an ardent feminist who was known to be far more outspoken than many of her fellow residents. She and Annie Goodrich were the Chairman and Vice Chairman of the Nurses’ Council of the National Woman’s Party, and when the NWP proposed the Equal Rights Amendment in 1923, Dock defended it to fellow nurses in *The Public Health Nurse*, a position which put her at odds with long-time friend Florence Kelley, who posted a response in opposition.⁷⁴ In 1910, she wrote *Hygiene and Morality*, in which she argued for a “single moral standard” in the fight against venereal disease and prostitution instead of the double standard that punished prostitutes and allowed men to roam untarnished (and never go through the medical

⁷¹ Lavinia L. Dock, *A Lavinia Dock Reader*, ed. Janet Wilson James, The History of American Nursing (New York: Garland Publishing, Inc, 1985), viii.

⁷² M. Adelaide Nutting and Lavinia L. Dock, *A History of Nursing the Evolution of Nursing Systems from the Earliest Times to the Foundation of the First English and American Training Schools for Nurses* (New York: G.P. Putnam’s Sons, 1907); Lavinia L. Dock and Mary Adelaide Nutting, *A History of Nursing: The Evolution of Nursing Systems from the Earliest Times to the Foundations of the First English and American Training Schools for Nurses* (Putnam, 1912).

⁷³ Carole A. Estabrooks, “Lavinia Lloyd Dock: The Henry Street Years,” in *Enduring Issues in American Nursing*, ed. Baer, Ellen D. et al. (New York: Springer Publishing Company, 2001), 282–308. Estabrooks did a nice analysis of all of Dock’s activities while based at Henry Street, which also included commitments to labor reform, suffrage, and professionalization of nursing.

⁷⁴ “The Lucretia Mott Amendment,” *The Public Health Nurse* XVI, no. 3 (March 1924): 135–136; Florence Kelley, “The Equal Rights Amendment,” *The Public Health Nurse* XVI, no. 4 (April 1924): 191–192.

examinations of regulation). She also argued that the best way to prevent prostitution was to eradicate poverty, enfranchise women, abolish child labor, and provide a living wage for girls.⁷⁵

Although visiting nurses made sure to distinguish themselves from religious orders who might attempt to convert or coerce those they aided, they did not dismiss the helpfulness of churches that wished to provide a kind of nursing service. Dock argued that nursing could be traced back to Dorcas in the Bible and that it developed in the Middle Ages as part of the nurturing care of female religious orders. Dock, in her articles and books on the history of nursing and visiting nursing, was always quick to credit “sisters of charity” as the origin of the practice of nursing care. “From that day to this,” Dock wrote, “visiting nursing has never ceased to be practiced by the orders of the Catholic Church.”⁷⁶

But simultaneously, Dock and other nurses put forth a specific definition of what “public health nursing” was and how the phrase should be employed in contrast to religious nursing. First, they did not wish to convert anyone, and wanted to make this kind of care secular and government-based. Furthermore, while they sometimes clung to an old tradition of moral responsibility, a religious code based on human dignity and universal brotherhood, they were also practicing the new scientific gospel of public health.

Although the term “public health nurse” did not come into use until the founding of the National Organization of Public Health Nursing in 1912, Wald was already performing the role before the turn of the century. Dock wrote to Wald’s biographer R.L. Duffus to explain why she felt that Wald deserved to be called the “First Public Health Nurse,” “as some may debate and

⁷⁵ Lavinia L Dock, *Hygiene and Morality; a Manual for Nurses and Others, Giving an Outline of the Medical, Social, and Legal Aspects of the Venereal Diseases* (New York: G. P. Putnam’s sons, 1910).

⁷⁶ Lavinia L. Dock, “Spread of Visiting Nursing,” *Charities and the Commons* 16 (April 7, 1906): 1.

others may dispute this.”⁷⁷ Dock started off her letter with the argument that a public health nurse should be judged not only by what she did, but also by her political philosophy about who had responsibility for the care of the sick. “First of all it would be correct wouldn’t it for the phrase itself to mean that public health should be regarded as a duty and obligation of governments both local and national and that the nurse who actively promoted this idea and worked for its realization not only in the medical but also in the nursing field would have joined those forces that believe in an active and useful government?” For Dock, the difference between the nurses in the preceding visiting nurse associations and the public health nurse was that a public health nurse had a broader view of her responsibilities, one that included a form of activism directed at governments and intended to make more far-reaching structural changes to transform health.

Dock elaborated on the differences between Wald’s service and those that preceded hers by saying that they did not have this “enlarged, rather daring view.” She did praise them for “organizing good, helpful nursing among the poor or those of small means” and for their “pure ... missionary, kindly, eager spirit.” Their limitations, she said, were linked to the fact that they were “managed by conservative boards that had to raise money among other conservatives,” and were “afraid to experiment.” She was more hesitant to reveal “that they were very subservient to the medical profession and fearful of displeasing them,” but felt that Duffus should know the background information. “Lillian’s discarding or ignoring this disciplined attitude was an important advance in her exploring expedition.”⁷⁸

⁷⁷ Lavinia L. Dock, “Lavinia Dock, Addressed to Mr. Duffus,” April 11 [year undated], Box 35, Folder 3, Lillian D. Wald Papers, Manuscripts and Archives Division, The New York Public Library.

⁷⁸ Ibid.

While Wald was busy changing the relationship of visiting nurses to their clients, she was also transforming nursing from within the profession. The kind of visiting nursing service that Wald set up created a new professional space for the nurse in which she worked mostly autonomously, with more independence from doctors and institutions. Other visiting nurses accepted calls only from the doctor, which then made the nurse subordinate to him; often when the patient chose a different physician the doctor would insist that the nurse be dismissed as well. But Wald could answer calls directly from families, saving time and money for the patients, and even if the family went through several different doctors, an independent nurse could continue caring for the patient and maintain continuity and stability.⁷⁹ She could provide the quality of care of private duty nursing without being treated like an employee or a housekeeper, and she was free of the bureaucratic hierarchy of the hospital and the paternalistic rules that nurses had to obey as live-in workers. Instead, she could live at the settlement, maintaining the sense of camaraderie and sisterhood she gained with other nurses during training, and develop a set of skills that was specific to nursing.

When Wald settled into the neighborhood, there were very few job opportunities for a trained nurse. After the Civil War, nurses were limited to working in a hospital or as private nurses in the homes of the wealthy. But hospitals with attached nursing schools had an endless supply of unpaid student nurses, and only those who could be promoted as superintendents, supervisors, or head nurses could stay on. For those nurses who did find jobs, hospital work could be very unpleasant, since they were stuck between obligations to both manage and teach a group of inexperienced students, while simultaneously keeping up the daily tasks their hospital

⁷⁹ Wald, *The House on Henry Street*, 35. Wald wrote that patients “may and often do change physicians from six to ten times in the course of an illness. The nurse, however, may remain at the bedside through all vicissitudes.”

duties required. The majority of trained nurses went into private duty nursing, where the nurse cared for one patient in his or her home. This work was sporadic and the duties changed from place to place. Furthermore, the trained nurse had to compete with untrained nurses, women who did the job of home care without hospital education, because many people still assumed that any woman could do nursing as part of her “natural” abilities. Finally, even if a trained nurse did secure a job, she might not have been treated any better than an untrained nurse, that is, as part of a domestic labor class that could be paid to do jobs that other women were expected, but often did not want, to do. The introduction of a nurse to a household with a staff could produce conflicts about hierarchy and what a nurse’s duties should be, and a nurse could be asked to perform tasks, like laundry or cooking, that she would consider outside the scope of her responsibilities.⁸⁰

Public health nursing, in contrast, was an ideal job for the trained nurse. They were able to claim a kind of expertise in preventive health that set them apart from the curative powers of doctors and gave them their own professional niche. They were able to work independently, visiting the homes of patients but not employed by them. Even though they paid lip service to the subordination of nursing to the medical profession, nurses did not have to take direct orders from doctors as much as private duty or hospital nurses. “More than either private-duty or hospital nurses, public-health nurses shook off their role as the physician’s hand, to set out and act on their own sense of nursing’s sphere and mission.”⁸¹ By the 1920s, as Barbara Melosh’s research

⁸⁰ Susan Reverby, “‘Neither for the Drawing Room nor for the Kitchen’: Private Duty Nursing in Boston, 1873-1920,” in *Women, Health, and Medicine in America: A Historical Handbook*, ed. Rima D Apple (New York: Garland Pub, 1990), 460–474.

⁸¹ Melosh, *The Physician’s Hand*, 114.

reveals, public health nurses were an elite corps among nurses who were able to “come closer than any other nurses to claiming the privileges of professionals.”⁸²

This kind of widespread autonomy for public health nurses did not solidify until later, however. Lillian Wald and other progressive nurses worked to create these avenues for nurses to perform their occupation with a new kind of independence. This began with the few nurses who worked at Henry Street Settlement. Wald continued to look for other employment opportunities for nurses that would improve and develop public health, but also give nurses a special kind of expertise and independence within the field. She was constantly looking for more ways to employ the visiting nurse to expand public health programs in state agencies and factories, deploying her reform impulse while creating a professional niche. In 1909, Lillian Wald convinced the Metropolitan Life Insurance Company that they would be able to save money on disbursements if a visiting nurse could improve health and lower mortality. Wald convinced Dr. Lee Frankel, founder of the Welfare Division of the Metropolitan Life Insurance Company, to employ visiting nurses to care for their industrial policyholders as a benefit, which Wald called “an important event in the annals of visiting nursing.”⁸³ The combination of social reform and social insurance meant that eventually Frankel and Wald would prove that health could be profitable. This program provided so many jobs for visiting nurses that Lillian Wald nicknamed the agency “Mother Met.” From the standpoint of the Metropolitan Life Insurance Agency, public health care could mean that their subscribers would not succumb to premature death from preventable causes and thus there would be fewer claims for expensive payouts. The project

⁸² Ibid.

⁸³ Wald, *The House on Henry Street*, 62.

grew over time, and by 1921 Mother Met was providing regular work to 887 visiting nurse associations, and also kept 338 public health nurses on their own payroll.⁸⁴

Public health nurses were linked with the reform movement from their earliest endeavors, and as settlement houses and other reform opportunities developed for women, public health nurses also had more places to work. Wald encouraged the employment of public health nurses in state agencies (school nurses), in workplaces (industrial nursing), and a variety of other specialties, such as maternity and tuberculosis nurses. She created demand for public health nurses in a variety of venues, both public and private, and thus these nurses had greater autonomy in their specialties.

In 1890, there were 21 organizations providing visiting nurse services, most of those with only one nurse. After 1894, there was a rapid expansion of such associations, and by 1905, there were 171 associations, in 110 different cities, employing a total of 445 trained visiting nurses. At the publication of Ysabella Waters's *Directory* on August 1, 1909, she counted 556 associations and 1413 nurses.⁸⁵ By Lavinia Dock's count, there were 1902 agencies by 1911.⁸⁶ In 1912, Ysabella Waters published *Visiting Nursing in the United States* as a guide to all of the organizations in action.⁸⁷ Typical of Progressive Era data-collecting, the second section of the book is a directory with details on every VNA state-by-state, with information on the number of nurses, their hours and payments, and the types of special care they might provide. But it also served as a kind of handbook for starting up a service in a community, and outlined the

⁸⁴ Melosh, *The Physician's Hand*, 117.

⁸⁵ Ysabella Waters, *Visiting Nursing in the United States, Containing a Directory of the Organizations Employing Trained Visiting Nurses* (New York: Charities Publication Committee, 1909), 14.

⁸⁶ Lavinia L. Dock, "The History of Public Health Nursing," *The Public Health Nurse* 14 (1922): 524.

⁸⁷ Waters, *Visiting Nursing in the United States*.

principles and structures of the more successful of the associations. Waters was also careful to lay out a general philosophy of public health, as well as the expectations for the education of a trained nurse working in the field.

As visiting nurse associations grew and expanded, they needed to coordinate and share information, and also needed to mobilize for professional and educational standards. At first, the only true nursing journal they had was *The American Journal of Nursing*. The very first issue in October of 1900 already contained articles on Visiting Nursing in its pages, with contributions by Lillian Wald and Lavinia Dock. By 1902, there were articles published on the Henry Street Settlement, the history of visiting nursing, and “experiments” in visiting nursing, such as school nursing.⁸⁸ The articles continued over the years, and beginning in 1908, Harriet Fulmer, who had previously edited the short-lived *Visiting Nurse Quarterly* for the fellow members of the Chicago Visiting Nurse Association, began heading a regular column on visiting nursing. Edna Foley, the director of the Chicago VNA, succeeded her.⁸⁹ Visiting nurses were also communicating with participants in the broader reform community. By contributing articles to the weekly reform magazine *The Charities and the Commons* (later *The Survey*), it was clear that they were keeping themselves in both worlds. In April of 1906, the publication even committed itself to a “Visiting

⁸⁸ “Nurses’ Settlement District Bag, In Editor’s Miscellany,” *The American Journal of Nursing* 1, no. 10 (July 1901): 766–773; L.L. Dock, “School-Nurse Experiment in New York,” *The American Journal of Nursing* 3, no. 2 (November 1902): 108–110; Honnor Morten, “The London Public-School Nurse,” *The American Journal of Nursing* 1, no. 4 (January 1901): 274–276; Lillian D. Wald, “The Nurses’ Settlement in New York,” *The American Journal of Nursing* 2, no. 8 (May 1902): 567–575; Lillian D. Wald, “The School Nurse in New York City, in Official Reports of Societies,” *The American Journal of Nursing* 3, no. 3 (December 1902): 221–222.

⁸⁹ Fitzpatrick, *The National Organization for Public Health Nursing*, 16.

Nursing Special Issue” with articles on the history and development of various VNAs in the United States and England.⁹⁰

Partly because of this dual identity as reformers and nurses, visiting nurses began to see themselves in need of their own organization. The American Nurses Association was a professional group limited to nurses; but visiting nurses needed to have relationships with other reformers, not just other nurses, and argued that lay members needed to be a part of the organization.⁹¹ In 1912, they met and formed the National Organization for Public Health

Nursing, and Lillian Wald was made the first president. They also decided on the name National Organization for Public Health Nursing (rather than “Nurses”) to emphasize that public health

⁹⁰ “Visiting Nursing Special Issue,” *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance* 16 (April 7, 1906): 1–69; Dock, “Spread of Visiting Nursing”; Lavinia L. Dock, “As the Nurse Sees It,” *Charities and the Commons* 16 (April 7, 1906): 10–12; Lina L. Rogers, “Nurses in the Public Schools of New York City,” *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance* 16 (April 7, 1906): 65–69; Honnor Morten, “School Nurses in England,” *Charities and the Commons* 16 (April 7, 1906): 62–65; “The Development of Nurses’ Settlements: In the Day’s Work of the Settlement Nurse,” *Charities and the Commons* 16 (April 7, 1906): 41–44; Elizabeth Ashe, “The Development of Nurses’ Settlements: Nurses’ Settlements in San Francisco,” *Charities and the Commons* 16 (April 7, 1906): 45–47; Lillian D. Wald, “The Development of Nurses’ Settlements: The Henry Street (The Nurses) Settlement, New York,” *Charities and the Commons* 16 (April 7, 1906): 34–41; Margaret H. Pierson, “The Development of Nurses’ Settlements: The Orange Visiting Nurses’ Settlement,” *Charities and the Commons* 16 (April 7, 1906): 48–51; Lillian D. Wald, “The Henry Street (The Nurses) Settlement,” *Charities and the Commons* 16 (April 7, 1906): 36–37; Amy Hughes, “The Rise of District Nursing in England,” *Charities and the Commons* 16 (April 7, 1906): 13–16; Waters, “The Rise, Progress and Extent of Visiting Nursing in the United States”; “The Visiting Nurse in Chicago’s Public Schools,” *The Survey (Charities and the Commons)* 15, no. 7 (November 18, 1905).

⁹¹ Mary Sewall Gardner, *Katharine Kent* (New York: Macmillan Company, 1947); Mary Sewall Gardner, *Public Health Nursing*, 2nd Edition, Completely Revised (New York: The Macmillan company, 1930); Fitzpatrick, *The National Organization for Public Health Nursing*. The National Organization for Public Health Nursing also inherited Cleveland’s *Visiting Nurse Quarterly* as its own journal as a “christening present” from the Cleveland VNA (*Katharine Kent*, 131). As nursing historian M. Louise Fitzpatrick pointed out, this serial “provided a vehicle for group consciousness and identity and definitely met a hard-felt need”(17). In 1913, the name was changed to *Public Health Nursing Quarterly*. In 1918, it switched to monthly publication and renamed *The Public Health Nurse*. From 1931 until the end of its run in 1952 it was called *Public Health Nursing*.

nursing included a variety of reformers and community members supporting each other in a joint effort.

England's "district nurse" had taken on a variety of titles in the United States, but most often they called themselves "visiting nurses." After the new national organization was established, they became more widely known as "public health nurses." Annie Brainard wrote about the significance of the new term: "And so the new title was adopted...for all forms of visiting nursing, which might or might not include bedside care. Henceforth school, factory, tuberculosis, child welfare, or any other form of social nursing—public or private—already existing or as yet undreamed of—would go by the name of public health nursing. It would be known, as not only for the relief of the sick, but for the preservation of the public health as well; not only for the poor, but for all."⁹²

Despite the emphasis on the "public" of public health nursing, Henry Street was completely privately funded. In the early days, Wald was supported fully by Jacob Schiff and Betty Loeb, but as the settlement expanded, so did its financial needs. In the year 1917, income came primarily through contributions (\$73,254.05), followed by the payments from the industrial and insurance companies for visiting nurse services (\$51,056.18). Although many individual patients were able to pay fees on a sliding scale, that accounted for the least amount of income (\$11,566.75).⁹³ The settlement had many other prominent politicians and philanthropists offering their support as well, such as the Morgenthau, Lehman, Crane, McCormick, Belmont, and

⁹² Brainard, *The Evolution of Public Health Nursing*, 333.

⁹³ Henry Street Settlement, *Report of the Henry Street Settlement 1893-1918* (Henry Street Settlement, 1918), 83.

Warburgs.⁹⁴

Wald had a close and enduring alliance with her primary benefactor, Jacob Schiff, but she also had a talent for nurturing relationships with all of her donors. Wald shared important lifetime events with those whom she courted for support, which enabled the settlement to call upon benefactors when she thought that their funds would be most necessary. One of the donors whom Wald wooed was Dorothy Whitney, a debutante from a wealthy family who had a mind of her own. Despite her society ties and family wealth, Dorothy focused more on her “social obligations” than on social climbing.⁹⁵ Whitney was orphaned at seventeen, and had an annual income of \$50,000 as stipulated by her father’s will. Dorothy was looking for “social work of a more serious nature,” and she consulted Addams and Wald for advice; she then began her reform work in earnest. Clearly influenced by their example, Dorothy joined the Junior League, and turned it from a social club into an active organization for aiding those less fortunate. An early activity of the group included home visiting in the place of schoolteachers who didn’t have time to do so. She established the Junior League House in 1911 as a tenement for working girls in which they could live independently and pay for it themselves, while being provided with the cultural and recreational amenities of the facility and the support of the matron.

The consultation that led to this project also formed a long-lasting relationship with Wald that included financial support for the settlement. After Whitney’s \$100 gift to the emergency fund in 1908, Lillian Wald suggested to the head of one of the satellite settlements that she contact the donor for additional funds. In a letter dated June 16, 1909, Head of the Henry Street Settlement’s branch in the Bronx, Harriet A. Chichester, wrote to Dorothy Whitney to request

⁹⁴ Coss, *Lillian Wald: Progressive Activist*, 10.

⁹⁵ Eric Rauchway, *The Refuge of Affections: Family and American Reform Politics, 1900-1920* (New York: Columbia University Press, 2001).

replenishment. The nurse included a letter from the sixteen-year-old boy in the “incipient stages of consumption,” whose “outfit” for a recuperative trip to Otisville Sanitarium would be paid for by the donation. Since he was already earning a wage, his parents were hesitant to let him leave work for his health; ultimately they agreed, but said that they couldn’t cover those particular costs. Chichester included an accounting of all the expenditures, which added to \$87.18.⁹⁶ As much as it was a request for funds, it was also an explanation of the many good uses of the funds that had already been granted, while also demonstrating good record-keeping and justifying spending choices.

In July of 1911, Wald wrote to Dorothy Whitney both to thank her for a donation and to congratulate her on her betrothal to Willard Straight. She wanted to respond to Whitney’s letter for “bringing its affectionate message to me personally and its generous check for the things that are precious and the people who are to precious to us all.” Wald’s letter is a lovely response that keeps a personal tone in addressing Miss Whitney’s own life while still focusing on the largesse and concern for social justice that Whitney and Wald shared. “It gave me such genuine pleasure to know that you were happy in your own right as well as through the happiness of others which I have known you to care so much about.”

Wald had also heard about Straight through mutual friends, and was glad that Miss Whitney had found someone who shared her social concerns. Straight’s reputation as a socially directed gentleman preceded him, notably via Mrs. Schiff, and Wald was pleased that he would support her in her social commitments. “I have known of him and his interests a long time and it seems quite splendid that you are mate-ing with one who from all stories concerning him will

⁹⁶ Harriet A. Chichester, “Letter to Dorothy Whitney to Request Additional Emergency Funds,” June 16, 1909, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

uphold your big public interests.” For Wald, it sounded like a perfect match: “It seems to me the modern marriage of mind as well as heart.” Wald clearly didn’t want matrimony to pull the progressive reformer Dorothy Whitney into the domestic constraints of Mrs. Straight.⁹⁷ Wald ended her note with a little business about how the money that Whitney had sent had been used among multiple activities and accounts. “I have divided up the “extra money” you sent between the scholarship fund—the children 14-16, whom we are keeping in school and vocational training, some of the summer work, the country [home] for convalescents, and the ‘emergency fund’ upon which we draw for special needs for the sick.”⁹⁸

Miss Whitney truly appreciated this response, and felt it to be warm and sincere. “You have no idea how much I appreciate your letter and all the splendid things you say—it means a great deal to receive just this kind of congratulation—for I know you truly feel something you write—and that’s what really counts. And you have said the very things about marriage which form the ideal of it—I do believe truly that to be really happy, one must have big interests in common and work hard together for those things which are really worthwhile.” This letter ended with the promise of sending \$50,000 “for you to use as you might,” but Whitney wanted it kept anonymous. “Please—say nothing about it, will you?” It seems like the wedding present was not to the bride, but to the settlement, as if to reassure both parties that Dorothy Whitney would not forget the high ideals she carried with her into marriage.

Wald wrote to the new “Mrs. Straight” in November of 1912, and along with her note sent a crib spread made by her mother to celebrate the birth of the Straights’ son, Willard

⁹⁷ Rauchway, *The Refuge of Affections*.

⁹⁸ Lillian D. Wald, “Letter to Dorothy Whitney to Congratulate Her on Her Engagement,” July 27, 1911, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

Whitney Straight, who had been born two days before.⁹⁹ Wald wrote that she had told her mother of Straight's "eagerness for social right—and about the baby," and that she had wanted to provide a special gift "to welcome the child."¹⁰⁰ After hearing the news of Dorothy's next pregnancy, Wald wrote a very poignant letter in which Wald made the compelling distinction between "personal motherhood" and implicitly, the "public motherhood" to which both she and Straight were contributing. "I am glad with you and very happy with you over the wonderful news. Thank you for telling me and letting me include the tender growing life that is to be in my loving thought of you. I keep wishing and wishing I could do something to impart to you the sense of love and pride I have in your sweet goodness and big understanding. This personal motherhood—it fills me with awe and tenderness and it is a part of your larger life too. I am so glad you have both and I wish I could express what is within my heart."¹⁰¹

She continued to thank Straight for her donation, and connected her "big understanding" with the lives of individual children. "And many many gratitudes for the great gift to the sick—they are so frequently children. That in a very real way the money gives life as it expresses love and sympathy." Wald made the connections between the life that Dorothy was giving through birth to the life she was also giving to other children through her donation. Wald made the connection between those two kinds of care explicit, and brought together what were no doubt Straight's two biggest concerns as one and the same.

⁹⁹ Rauchway, *The Refuge of Affections*, 51.

¹⁰⁰ Lillian D. Wald, "Letter to Dorothy Straight to Congratulate Her on Her New Baby," November 8, 1912, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

¹⁰¹ Lillian D. Wald, "Letter to Dorothy Straight," April 20, 1914, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

It seems that Wald's peace activism during WWI might have cooled the relationship between Lillian Wald and the Straights, as her association with the American Union Against Militarism eventually did with many of her other donors. On September 24, 1915, Wald wrote to Dorothy to invite her to a dinner party to discuss the war with several authorities. She also expressed regret that Dorothy had not been at the meeting with Jane Addams, presumably on the same subject. But she quickly requested an RSVP for the dinner party and then moved onto financial issues. "The nurses of the Settlement are tremendously active, and the nursing work has not lessened during the summer months. We are facing an equally heavy winter. When you find that you can do so, will you remember the \$25,000 that you were to give to the Endowment Fund? With your \$25,000 that Fund has now reached about \$250,000. None of us has been aggressive about it, partly because last year seemed to be an infelicitous time to urge the needs of the Fund. I have not changed my mind, and I hope you have not either, as to the importance of lifting this enormous service from the precarious financial hazard upon which it now rests."¹⁰²

Wald and Addams were amping up their activities in the peace movement, but it appears that Straight might have been more torn, as even Wald suggested. A few days later, Wald wrote Dorothy a frantic entreaty fearing she had somehow upset her. "At the risk of appearing insistent may I ask if I have in any way hurt or offended you? You are associated in my mind with wonderful kindness and spiritual perception that have sometimes made life appear more worthwhile and I treasure two or three of your letters that to me are of inestimable worth because they seemed the expression of one who felt and understood. That is my reason for entreating you to let me know where I have failed. I would be discouraged beyond any power of expression if

¹⁰² Lillian D. Wald, "Letter to Dorothy Straight," September 24, 1915, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

unknowingly I had offended you—knowingly to do so would be impossible.” This all left Wald “unhappy and perplexed.”¹⁰³ Straight responded to clarify the confusion about her donations and apologized for any misunderstanding, and Wald wrote back quickly to express her great relief.¹⁰⁴ Even if Straight’s response had been a withdrawal of financial support, not of friendship, it is clear that these were very difficult to untangle.

Wald was able to keep the financial commitments of her donors ongoing by maintaining close personal ties, and when finances were withdrawn, it could feel like a loss of friendship as well. Much of the work of her job was not just nursing, but courting benefactors and reporting and justifying her spending. This correspondence between Dorothy Whitney Straight and Lillian Wald demonstrates Wald’s tact and personal touch. Although Dorothy Whitney was no doubt considered a kindred spirit and possibly a friend, the maintenance of their correspondence also included requests for financial assistance, and the maintenance of support required certain society charms and connections. It must have been a fine balance maintaining such a long list of business friendships, but Wald seemed to do it honestly, with warmth and tact.

Clearly, fundraising was a big part of Wald’s job running the settlement house. But just as Wald was looking to find new avenues of employment for other public health nurses like herself, she

¹⁰³ Lillian D. Wald, “Letter to Dorothy Straight,” November 29, 1915, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

¹⁰⁴ Dorothy Whitney Straight, “Draft of Answer to Letter by Lillian D. Wald from November 29, 1915,” December, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library; Lillian D. Wald, “Letter to Dorothy Straight,” December 2, 1915, Collection #3725, Box 2, Folder 48, Dorothy Whitney Straight Elmhirst Papers, Division of Rare and Manuscript Collections, Cornell University Library.

also wanted to expand these kinds of health care initiatives into the public realm. Wald considered many of her settlement house programs to be experimental initiatives—pilot programs—that should be tried out in the settlement house and then taken over by state agencies. Lillian Wald’s importance has been established separately in the fields of the development of public health and in reform but in Wald’s case, those roles are inseparable.¹⁰⁵ Her version of the public health nurse was a reformer, or “progressive nurse,” who believed that health was a social issue and that health care for all was a necessity and right. Wald argued that bad health was caused by social problems, such as poverty and ignorance, which she hoped to alleviate through inexpensive care and education. She and other progressive nurses argued that bad health could *lead to* further social problems, such as truancy and ultimately delinquency, resulting in a continuous cycle of poverty and crime. By attacking the issue of health preventively, and early in life, progressive nurses sought to improve the ability of immigrants to better their living conditions and make way for a changed future.¹⁰⁶

School nursing was one of the crucial ways the philosophy of visiting nursing expanded into more arenas. Very early on, Wald and Brewster noticed the number of children kept out of school for minor health issues. Even in the first years when it was just the two nurses, they “decided to keep memoranda of the children we encountered who had been excluded from school for medical reasons” and they continued to collect data as more nurses were added to the

¹⁰⁵ Buhler-Wilkerson, *No Place Like Home*; Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900-1930*, Garland Studies in Historical Demography (New York: Garland, 1989); Karen Buhler-Wilkerson, “Bringing Care to the People: Lillian Wald’s Legacy to Public Health Nursing,” *American Journal of Public Health* 83, no. 12 (December 1993): 1778; Karen Buhler-Wilkerson, “Left Carrying the Bag: Experiments in Visiting Nursing, 1877-1909,” *Nursing Research* 36, no. 1 (February 1987): 42–47; K Buhler-Wilkerson, “Public Health Nursing: In Sickness or in Health?,” *American Journal of Public Health* 75, no. 10 (October 1985): 1155–1161. Daniels, *Always a Sister: The Feminism of Lillian D. Wald*.

¹⁰⁶ Wald, *The House on Henry Street*; Wald, *Windows on Henry Street*.

staff. Through their communications with the nursing community, they had also learned of similar experiments in England.¹⁰⁷

Indeed, Wald wasted no time in getting started in New York City. She was motivated by her daily encounters with neighborhood children who were kept out of school. She wrote that meeting a boy named Louis with a minor skin condition had prompted her to take action. Louis had spent very few days in school, despite desperately wanting to attend, and at twelve years old was still unable to read. He had told her, “Every time I go to school Teacher tells me to go home.” Wald sympathized with teachers who did not have time to deal with the medical

¹⁰⁷ Morten, “The London Public-School Nurse.” The first experiment with putting nurses in schools took place in London, England. In 1897, the London School Nurses Society was formed in order to provide care to elementary-age children in the poorer districts. It was a voluntary organization funded by contributions, and headed by Honnor Morten, a nurse, prominent social reformer, settlement founder, and member of the School Board. School nursing in London was not a project that was initiated by the local government, although its creation was dependent on the networks that progressive reformers had formed between voluntary organizations and state institutions. The London School Nurse Society had to gain permission to enter the schools, and it was not until 1904 that school nursing was finally under municipal authority and out of the hands of private associations.

Honor Morten first published her account of the work in the *American Journal of Nursing* in January 1901 under the journal’s recurring section “Progressive Movements.” Many of the justifications and goals that Honor Morten described were representative of a progressive belief in preventive medicine, and would be shared by other school nurses when the concept spread to the United States and Canada. She relayed the need for immediate intervention in the health of children, the role for hygiene education, and the necessity of securing treatment for children.

Morten presented the case for a partnership between doctors and nurses in the schools. There was no system of medical inspection in London such as the one in place in American cities at the time; according to Morten, the sole permanent medical officer in London was a bureaucrat who collected statistics. She admitted the need for medical inspectors in London school districts, but she simultaneously issued a call for New York to add nurses to their own scheme. She argued that nurses would be more useful since they actually treat the children, even following up with them in their homes, instead of just keeping them outside the school doors.

Lillian D. Wald was certainly aware of the school-nurse experiment in London, and had introduced Honor Morten and her work in the preface to the *American Journal of Nursing* article. Wald had always hoped to get trained nurses into the public schools of the immigrant quarters of the city in which she worked and wanted to make the London experiment known to American social reformers to win interest for a similar movement in the United States.

problems of individual students, especially when the schools were already overcrowded, but she lamented that a child should lose out on his education because of an easily treated malady. Wald also implied that perhaps Louis's mother was too busy to attend to his minor ailments. His mother worked as a washerwoman to earn a living, and when Wald met her, she was hunched over a tub scrubbing butchers' aprons with her right hand, while carrying around a baby in the left. Wald said that it only required "intelligent application of the dispensary ointments" to cure Louis's eczema, and for the first time in his life he was able to attend school regularly the following September. As Wald told it, "Louis set me thinking and opened my mind to many things."¹⁰⁸

School nursing resulted from the trajectory of the nursing profession that was gaining more independence and creating new specializations. Lillian Wald's nursing service help to create a space for another profession that had traditionally been considered "women's work." As visiting nursing turned into public health nursing, and specializations like school nursing were created, there was a growing market for nurses. In extension, advocating for the use of nurses in schools was a way both to expand the role of the state in the provision of care and a way to give nurses greater status and new jobs with more independence. Women sought to amplify their roles and to advance their professions, and like other women professionals, nurses were gaining autonomy and beginning to occupy their own sphere within medicine. But the school was also a very important state agency that played a central role in the lives of children, and nursing met the needs of the community by providing healthcare to children who were overlooked and often forgotten in the shuffle of the public school system. Nurses were no longer handmaidens to doctors; they had a unique set of skills that could be applied to the social ills of the city.

¹⁰⁸ Wald, *The House on Henry Street*, 46–48.

Amid the bustle: An interlude on photographer Jessie Tarbox Beals



Jessie Tarbox Beals, climbing for her shot¹

One of the most poignant images of the nurses of the Henry Street Settlement, the photograph of the visiting nurse walking across tenement rooftops that opened chapter one is among the most frequently used images to represent the work of the public health

¹ Unknown Photographer, *Jessie Tarbox Beals Working at the Louisiana Purchase Exposition (The Ladder Is Supported by Her Assistant, "Pumpkin")*, Gelatin Silver Print, 1904, PC60-18-22, Radcliffe Institute, Schlesinger Library.

nurse.² This unidentified nurse, carrying her bag with all of her supplies, but still wearing the crisp and presentable uniform and hat, is using a bit of the detritus on the rooftop as a step to hoist herself over the brick wall that guards the division between the buildings. In contrast to the stark and angular background of the city, with its boxes and grids and grit, she is round and feminine, her curves accentuated by the lifted arm and knee. This nurse, the representative of all that is feminine and maternal, is framed by outdoor spaces that are considered the most threatening: the city, the slum. At a time when most women were not supposed to venture outside the home, she is a woman literally climbing over barriers that have been put before her, and reveals the creative ways that visiting nurses challenged the limitations of gender to create new professional spaces for themselves.

Although this photo is often invoked to demonstrate the nearly super-human feats of the Henry Street nurses as they glide across the skies—“real superheroes!” one commenter posted on a blog about the history of New York City—or even their angelic qualities, in fact it reveals the very hard work that nurses performed daily: the physical labor of walking the neighborhoods to get from one home to another, and in this case, taking a short cut over the top of the buildings to avoid trucking up yet another flight of stairs. This photograph shows a woman at work.

But where did this image come from? Where was it originally published? Only as I started collecting photographs that I wanted to use, photocopying them and laying them side-by-side, did I realize that many were marked with the same name: “Beals, N.Y.” My first thought was: “Who was this guy?” I was more than a little ashamed when a

² Jessie Tarbox Beals, *Visiting Nurse on Hester Street, Traveling over Rooftops*, 1908, Visiting Nurse Service of New York Records, 1889-2007, Health Sciences Library Archives and Special Collections, Columbia University Medical Center.

quick search led me instead to “Jessie Tarbox Beals: First Woman Photojournalist.” This photograph is now a part of the collection of the Visiting Nurse Service of New York, held at the Columbia Rare Book and Manuscript Library.

Most of Beals’ photos of the Lower East Side were taken around 1910 for the Association for Improving the Condition of the Poor; according to Cathy Alexander, the Association used photographs to document their good works and to expose conditions in order to promote legislation.³ Until 1910, they mostly used photographs taken by the social workers on their staff to illustrate their annual reports and to promote their cause, but then decided it was worth the investment to bring in professional photographers and pay them to deliver high-quality work: Lewis Hine, Jacob Riis, and Jessie Tarbox Beals were among those hired.⁴

Jessie Tarbox, just eighteen years old, was a schoolteacher in a small Massachusetts town when she won her first camera set by selling magazine subscriptions. The set came with a camera, tripod, and six plates, along with printing paper and chemicals. It was a cheap, tin-box of a tool, but it would start her on the path away from a monotonous, miserable job and into the world of professional photography. By the following summer vacation, she decided to try her hand at selling her pictures, and started a dark room and studio out of her home. She made more money during the summer than she did throughout the year at her teaching job. Eventually, she would abandon teaching altogether to marry Alfred Beals, to whom she taught photography basics and who

³ Cathy A. Alexander, “Photographing the Poor,” *Columbia Columns* 32, no. 1 (November 1982): 24.

⁴ The New York Association for Improving the Condition of the Poor would be combined with other organizations to form the Community Service Society in 1939, and these photographs are housed under that name at Columbia Rare Book and Manuscript Library.

worked as her partner in work and life for years to come.

In 1899, she would sell her first photograph to the press in Greenfield, Massachusetts, and that started her on her way to becoming a photojournalist. She worked for a year or so as an itinerant photographer before she moved to Buffalo, New York, working as a news photographer for the *Buffalo Inquirer* and the *Courier*, where she gained the reputation as a talented go-getter who could match the male photographers in their ability to work the physically demanding job. Jessie Tarbox Beals furthered her career through her work at the St. Louis Exposition, taking photographs of the people of the international displays, the exotic and “primitive” peoples from around the world who served as contrast to the advanced technological and cultural exploits of the Western world put on pageant in the main section of the park.⁵ She took photographs of the Native American tribes, the groups from the Philippines, Zulus and Hottentots, and native Patagonians and Japanese, among others. But she also gained prestige by capturing photographs of President Theodore Roosevelt and his family, including an exclusive perspective on his auto parade from a twenty-foot ladder, and aerial photographs taken from a hot-air balloon.

It was this success in St. Louis that led her to move to New York City in 1905 and try to establish herself in the heart of the newspaper world, but she made her money in as many ways as she could find. She took portraits of the wealthy for magazines, or found clients in their homes, and also attended events and sold prints to participants. At times, she had gone door-to-door to offer in-home sittings. She was known for her quick turnaround on prints, even during the busiest of times, mostly thanks to the aid of her

⁵ Robert W. Rydell, *All the World's a Fair: Visions of Empire at American International Expositions, 1876-1916* (Chicago: University of Chicago Press, 1984).

skilled husband, and was thus able to earn a living.

Beals probably considered her work for the Society as more of an assignment than a mission. She wrote, “I am photographing tenement house conditions for the purpose of reform and tubercular prevention—work that I could not do a year ago, but which I have grown up to.”⁶ She should not be confused with Lewis Hine or Jacob Riis; she was not using her photography for the purpose of social reform like these more well known photographers who captured the same subjects. Adele de Leeuw, a children’s writer who knew Beals, insisted that Beals did not share the same commitments as the reformers. “I know she did studies of poor children, but Jessie was definitely not a bleeding heart.”⁷ But Riis and Hine did not capture the work of women in quite the same way Beals did.

It is hard to imagine any other photographer of her time able to catch this simple moment of the day in the life of a visiting nurse. As she snapped this photo of the nurse climbing over tenement rooftops, she might have been thinking of the time she climbed a bookcase in the reporter’s room of a Buffalo courthouse to sneak a photo from an open transom before being caught. She charmed her way out of trouble by coquettishly chastising the sergeant about all of the dust ruining her dress. She was clearly no stranger to utilizing her feminine charms alongside the physical strength and endurance required of a photographer who was on her feet all day. She might, too, have been thinking about her photographs at the St. Louis World’s Fair, when she commandeered that twenty-foot ladder to get a better view of an auto parade.

These professional women in the vanguard would literally need to go to any

⁶ Alexander Alland, *Jessie Tarbox Beals: First Woman News Photographer* (New York: Camera/Graphic Press, 1978), 67.

⁷ Ibid.

heights to make it in their new careers. “My teaching was a genteel, sheltered, monotonous and moneyless work having neither heights nor depths,” Beals would later write.⁸ Her description of her womanly teaching career is reminiscent of the way that Lillian Wald described the constraints she felt during her own childhood in Rochester. To catch that moment—that bit of work and freedom of climbing over the rooftops—was to show the respect she might have felt for other women who were pushing the boundaries of their own “genteel” upbringings to break ground as professionals. In both cases, pounding the pavement was a part of the task. And though she may not have shared the same zeal for reform that Lillian Wald possessed, Jessie Tarbox Beals could perhaps appreciate the ingenuity and hustle required of the nurses, porting equipment along with the heavy restrictive clothing. As the first woman photojournalist, she was familiar with the obstacles that women faced in the workplace. And she, more than any other photographer working the streets of the East Side in the early twentieth century, knew what it was like to work in skirts.

⁸ Ibid., 22.

Chapter Two

“Sound body as well as sound mind”:

Health, education, and democracy in New York City schools



Lina Rogers putting medicine in a child's eyes¹

“Is there not here involved a question to which the state should give its attention? ... The state recognizes its responsibility for the development of citizens. To meet this responsibility, the school is its most efficient agency. If for safe-guarding the state, mental training is made compulsory, is it not logical to conclude that physical development—the sound body as well as the sound mind—should as far as possible be demanded? From the obligation to cure to the obligation to prevent is but a single advance step in the growth of the civic conscience. Adequate and intelligent medical inspection would perhaps meet with less resistance if regarded, not as reform, but rather as a natural development of ideas held by the founders of the republic who placed the school on the same level with the home in responsibility for the maintenance of good citizenship.”²—Lillian Wald, 1905

¹ “Lina Rogers, First School Nurse, Puts Medicine in the Eyes of a Child,” in Ellen Paul Denker, ed., *Healing at Home: Visiting Nurse Service of New York 1893-1993* (New York: Visiting Nurse Service of New York, 1993).

² Lillian D. Wald, “Medical Inspection of Public Schools,” *Annals of the American Academy of Political and Social Science* 25 (March 1905): 96.

The first health efforts in schools focused on “buildings, not bodies.”³ In the 1870s and 1880s, health boards began to think about the physical setting in which children were educated; previously, there were no sanitary codes, even though many complained of the crowding, rancid air, and lack of toilets.⁴ Doctors were concerned that both schools and schooling were making children sick, with poor ventilation, bad lighting, and overwork.⁵ Public health inspectors worked to transform the school infrastructure and environment; their work was aligned with more general public health efforts during the same period that focused on structural concerns like clean water, sewage, and trash removal rather than on individuals or their illnesses.⁶

It was not until the 1890s that officials became concerned with contagion and made efforts to have children removed from school because of sickness. The medical inspection of children’s bodies began as a response to dangerous epidemics that repeatedly threatened cities in the nineteenth century. School medical inspection first began in Boston in 1894 as a response to a diphtheria outbreak, and the results of this program encouraged Chicago and New York to follow their lead.⁷

Doctors performed medical inspections on the children of New York City schools with the sole purpose of selecting those to be “excluded,” or sent home, if they showed signs of

³ Alan M. Kraut, *Silent Travelers: Germs, Genes, and the “Immigrant Menace”* (New York: Basic Books, 1994), 233.

⁴ John Duffy, “School Buildings and the Health of American School Children in the Nineteenth Century,” in *Healing and History: Essays for George Rosen*, ed. Charles E Rosenberg (New York: Science History Publications, 1979), 161–78.

⁵ Richard Meckel, “Going to School, Getting Sick: The Medical and Social Construction of School Diseases in the Late Nineteenth Century,” in *Formative Years: Children’s Health in the United States, 1880–2000*, ed. Alexandra Minna Stern and Howard Markel (Ann Arbor: University of Michigan Press, 2002), 185–207.

⁶ John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990).

⁷ Charles G. Dewey, “Medical Inspection of Schools in Boston,” *The American Journal of Nursing* 1, no. 9 (June 1901): 650–55.

contagion. Teachers identified those students they suspected of having an illness, and sent them to be looked at by the doctor. Inspectors did not make a definitive diagnosis, and the children did not receive treatment; inspectors left this to the parents, who were often unable or unwilling to pay for medical care or to treat conditions that were not life threatening. If the problem did not go away on its own, a child would be kept out of school indefinitely.



Lina Rogers, school nurse, and Dr. S. Josephine Baker, medical inspector⁸

Lower East Side, 1902

When the medical inspector arrived, the children scurried from their desks, and with a scolding from their teacher, put themselves in line. The doctor stood at the front of the room next to the windows, and the trail of bodies looped around the back wall. The motion of the line came in quick stops and starts, and distracted children tumbled into the backs of those in front of them.

When reaching the head of the line, each child paused with mouth open wide and used one finger to pull down the lower eyelid; the inspector peered past rotting teeth and then into itchy eyes. With his hand held up to his face, the child exposed the skin on his wrist, and the doctor glanced to spot the rashes that would tell of scabies or impetigo.

⁸ “The Superintendent of Nurses, Miss Lina Rogers, Inspects School Children [with Dr. Baker],” in *Fighting for Life*, by S. Josephine Baker (Huntington, N.Y: R. E. Krieger Pub. Co, 1980).

The close-up examination was hardly necessary. A quick glance across the horizon of heads could show the doctor enough to determine favus and lice: rough patches of skin on the scalp, a few thin strands of hair poking through baldness; sores forming, and on some, nits visible. Others were ill, scarlet fever or chicken pox sores still open.

Contagion had to be controlled. Doctors sent children home with notes: little coded forms with numbers circled. They told children to have their parents take them to the doctor. Children handed parents their cards; mothers squinted at the foreign words and symbols and placed them on the mantle. Boys and girls were sent out to play.⁹

The attention that public health administrators gave to immigrant children in schools was matched by the increased medical control of immigrants at Ellis Island. Authorities in the two locations used the same vocabulary to describe the process of medical examination. School children and immigrants had to go through “medical inspection” to determine their fitness, and if they were found to be carrying any diseases or defects, they could be “excluded”—sent back to their home countries or sent home from school.

At the turn of the century, immigrants were connected with plague in the minds of Americans, and immigration restriction reflected a fear about the health risks that immigrants carried with them. By 1900, nativists had long been arguing that native-born Americans were of a superior, more robust breed. They presented data to claim that the foreign-born were far more likely to suffer from certain diseases, and that allowing them to stay would dilute native strength.

⁹ This portion was fictionalized based on various accounts: S. Josephine Baker, *Fighting for Life*, Reprinted with historical introduction, Huntington, N.Y.: R. E. Krieger Pub. Co. 1980 (New York: Macmillan Co., 1939), 77–79; Lillian D. Wald, *The House on Henry Street* (New York: Holt and Company, 1915), 46–52; Lina Rogers Struthers, *The School Nurse; a Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease Among School Children* (New York and London: G.P. Putnam and Sons, 1917), 58–64. Multiple sources relay the ineffective system of school inspection that prevailed in schools at the time, but as a medical inspector, Baker was the only one to thoroughly describe “the line.” Rogers described her inspection, but also encouraged privacy and dignity.

Exclusion, nativists argued, was the only way to keep the American breed strong and pure.¹⁰



The Line at Ellis Island¹¹

Isle of Tears, 1900

As the rush of new arrivals pushed through the doors—families grabbing to stay together, mothers balancing baggage and babies—immigration officers gathered their papers and medical inspectors their instruments. The line was in motion.

The immigrants began their climb up the stairs to the Registry Room, while the inspectors stood at the top to observe the robustness of the passengers on their ascent. Watching chests heave and listening for wheezing breath, they silently took note of illness or infirmity. If they suspected heart trouble or disability, inspectors would quickly chalk secret messages to each other on the

¹⁰ Kraut, *Silent Travelers*, 5.

¹¹ Underwood & Underwood, *U.S. Inspectors Examining Eyes of Immigrants, Ellis Island, New York Harbor*, 1913, Library of Congress Prints and Photographs Division, Washington, D.C., <http://www.loc.gov/pictures/resource/cph.3a10036/>.

coats and clothes of passengers.

For those in line, there was a frantic anxious push of nerves as they were roped in by the slow waiting queue of bodies. The inspectors maintained an outward appearance of steady, slow officialness, but their minds raced through a checklist of categories and symptoms as they scanned each immigrant. Eyes glanced over bodies, hands flicked through hair with toothpicks or pencils, and finally, there was a quick jerk of the wrist as a buttonhook turned up an eyelid.

Reading the chalk coding system, the inspectors started separating the marked from the unmarked. Hands grasped the shoulders of those in line, steering them toward the labyrinthine enclosures where they would wait for their next inspections. A confused grandfather was chided when he tried to veer back to his family; he blinked angrily at the barrage of unknown words.

Although the symbols were secret, attentive watchers saw that it was quickly becoming a separation of the clean from the unclean, the wanted from the unwanted. A mother bent down to tie her son's shoe, and as she got back to her feet, she spit rapidly on her fingers to rub the chalk off his lapel. A pregnant woman with varicose veins turned her coat inside out and put it over her belly; she kept her suitcase held up close to her legs hoping to continue on unnoticed.¹²

¹² This section was extrapolated from a variety of sources describing the experience of medical inspection at Ellis Island, both from the perspectives of United States Public Health Service workers and immigrants. The individual examples are fictionalized, but medical inspectors did comment on ways that immigrants tried to hide defects or deceive doctors. See Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: Johns Hopkins University Press, 2003); Kraut, *Silent Travelers*; Dr. Alfred C. Reed, "The Medical Side of Immigration," *Popular Science Monthly* 80 (1912): 385–92; E. Yew, "Medical Inspection of Immigrants at Ellis Island, 1891-1924," *Bulletin of the New York Academy of Medicine* 56, no. 5 (June 1980): 488–510; Alison Bateman-House and Amy Fairchild, "Medical Examination of Immigrants at Ellis Island," *Virtual Mentor* 10, no. 4 (April 2008): 235–41; August C. Bolino, *The Ellis Island Source Book*, 2nd ed. (Washington, D.C.: Kensington Historical Press, 1990); Thomas M. Pitkin, *Keepers of the Gate: A History of Ellis Island* (New York: New York University Press, 1975); Peter M. Coan, *Ellis Island Interviews: In Their Own Words* (New York: Facts on File, 1997); J. Parascandola, "Doctors at the Gate. PHS at Ellis Island," *Public Health Reports (Washington, D.C.: 1974)* 113, no. 1 (February 1998): 83–86; Marie Jastrow, *A Time to Remember: Growing up in New York Before the Great War* (New York: W. W. Norton, 1979).

Only the steerage class passengers had to go through the medical inspections at Ellis Island. When the ship came into New York Harbor, the Immigration Services of the United States Public Health Service went on board and approved the first- and second-class passengers within the walls of their own cabins. Everyone had been warned of the possibility of exclusion; those who could afford the more expensive tickets purchased them when they could, since those passengers were rarely turned back. When the boat docked, the third-class passengers were loaded on to a barge and transported to Ellis Island, where they might be held up for days.¹³

The doctors of the United States Public Health Service perfected their “medical gaze” as the chief method for separating out and certifying immigrants at Ellis Island.¹⁴ As the prospective citizens made their slow march, doctors began their inspection from the feet and moved upwards to the head. Dr. Alfred C. Reed described the line inspection taking place on the island as “the most important feature of the medical sieve spread to sift out the physically and mentally defective.”¹⁵ Reed’s description revealed that the immigrants moved single file in two lines, and were required to make a turn directly in front of the inspector to allow him to get both a front and profile view, which would reveal a number of possible defects from afar.

“He sees each person directly from the front as he approaches, and his glance travels rapidly from feet to head. In this rapid glance he notes the gait, attitude, presence of flat feet, lameness, stiffness at ankle, knee, or hip, malformations of the body, observes the neck for goitre [sic], muscular development, scars, enlarged hands, texture of skin, and finally as the immigrant turns, in following the line, the examiner has a side view, noting the ears, scalp, side of neck, examining the hands for deformity or paralysis. ... As the immigrant passes on, the examiner has a rear view which may reveal spinal deformity or lameness.”¹⁶

¹³ Bateman-House and Fairchild, “Medical Examination of Immigrants at Ellis Island”; Fairchild, *Science at the Borders*.

¹⁴ Fairchild, *Science at the Borders*.

¹⁵ Reed, “The Medical Side of Immigration,” 386.

¹⁶ Ibid.

The doctor spent approximately six seconds on each immigrant during the line inspection.¹⁷

Medical inspectors gave extra attention to the eyes, and at the end of the line there was another doctor designated for this purpose. The inspector used a tool to evert the eyelids of each passerby for the examination; ostensibly, he was checking for any eye problems, such as cataracts or defective vision, but mainly sought signs of trachoma, a very contagious eye infection that led to blindness.

Any person who had been marked on the line, typically fifteen to twenty percent of the travelers, would be separated from the others and placed in cage-like waiting areas; from there, they would be taken to the gender-segregated medical examining rooms and stripped to the waist for a more complete examination.¹⁸ It might take several days or weeks to either “certify” or release an arrival.

The job of the medical inspector was to search each newcomer for any physical defects, and if any of those illnesses fell under certain categories that were reasons for exclusion, the immigrant would be deemed “medically certified.” The medical inspectors were classifying conditions according to the laws governing medical exclusions that were first established in 1891, when Ellis Island was taken under federal control to be used as a port of entry. Any immigrant arrival who suffered from a Class A condition—“a loathsome or a dangerous contagious disease—was to be medically certified.”¹⁹ By 1897, Class A diseases that were considered to be “dangerous contagious diseases” included trachoma and tuberculosis; those that were “loathsome” were favus, leprosy, syphilis, and gonorrhea. By 1903, the United States Public Health Service had issued the *Book of Instructions for the Medical Inspection of*

¹⁷ Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” 489.

¹⁸ Fairchild, *Science at the Borders*, 98.

¹⁹ *Ibid.*, 32.

Immigrants and further outlined the federal laws regulating medical certifications, which expanded the list of Class A conditions to include two other subdivisions: Insane Persons and Idiots. It also included a section of Class B certifications: “Aliens excluded as likely to become public charges,” that is, those suffering from “diseases and deformities which are likely to render a person unable to earn a living.”²⁰ This was a lengthy list, including pregnancy, hernia, varicose veins, senility, deformities, and “poor physique,” but it allowed room for the medical inspector to make his own determination under this category.

The medical inspectors had no final say over who was allowed to enter the United States; the certificates would be passed forward to the officers of Immigration Services, who would consider medical conditions along with other factors before Immigration made a final decision over entry. The number of immigrants actually denied entry to the United States remained very low, but increased gradually over the years. Between 1900 and 1914, the years when the highest numbers of immigrants passed through the nation’s doors, the number of exclusions wavered around one percent; the highest percentage of exclusions was 2.5 percent, reached in 1914.²¹

Although the actual number of exclusions due to medical causes was statistically very small, the psychological effect on immigrants was considerable. Even before departure, immigrant aid associations and steamship brochures warned immigrants about medical inspection and gave travelers an idea of what to expect upon arrival at Ellis Island. Every passenger had also already experienced a prerequisite medical screening before the ocean journey, since the United States government made the deportation of any medically certified

²⁰ United States Public Health Service, *Book of Instructions for the Medical Inspection of Immigrants* (Government Printing Office, 1903).

²¹ Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” 92.

immigrant the financial responsibility of the steamship company that transported them.²² Even the possibility of deportation was frightening; many immigrants had used their entire life's savings to make the journey to the United States, and for some, being returned to the port of departure meant not only financial hardship, but the return to a life of persecution and even genocide.

Medical inspection loomed large in the experience of immigrants arriving at Ellis Island, and for many, it was the most memorable event of their entrance to the country. Even in old age, many recalled the medical inspection as the most harrowing part of the journey. For children, it could mean separation from parents without explanation and for an unknown period of time; for others, stripping to the waist in public might have violated a deep modesty, and mothers were humiliated that their children saw them undressed. The fear of being debarred for medical reasons was very strong for every immigrant. One of the myths at Ellis Island was that every person who was medically certified would be deported, and that one had to be "perfect" to be allowed through the golden door.²³

These fears were not unfounded. Medical reasons were increasingly cited as the cause for deportations: in 1898, 18 percent of deportations were for medical causes, 38 percent in 1908, and 57 percent in 1913; by 1916, 69 percent of exclusions were based on medical certifications.²⁴ The language of exclusion was prevalent in the discussion of medical inspection, because medical inspectors shared the belief that they had an important responsibility to allow only the most desirable through the nation's borders. As Alfred Reed stated in 1912, "The first rule of national life is self-preservation, and since immigration has had and still has so important a role

²² Fairchild, *Science at the Borders*, 1.

²³ Yew, "Medical Inspection of Immigrants at Ellis Island, 1891-1924," 508, note 57.

²⁴ *Ibid.*, 499-500, 92.

in American national life, it must be carefully scrutinized to determine which immigrants are desirable, and *vice versa*, from the standpoint of the betterment and continuance of the American nation.”²⁵

The United States Public Health officers began to understand some illnesses as “immigrant diseases”: trachoma, favus, and ringworm; to a lesser degree, tuberculosis, syphilis, and gonorrhea.²⁶ Trachoma was added to the list of dangerous, contagious diseases in 1897, and would hold the top spot as an immigrant disease for years to come. Although now trachoma is for most an unfamiliar word, let alone condition, in the early part of the twentieth century it was a topic of utmost concern for medical inspectors, public health workers, and immigrants themselves. The paranoia that trachoma inspired in the American public far outweighed the actual risk of trachoma carried by immigrants. As historian Howard Markel put it, “Between 1897 and 1925, the average annual number of trachoma cases diagnosed at American ports and borders was about 1,500—far less than 1% of the annual number of immigrants seeking entry during this period. Yet, for most Americans living during the Progressive Era, the newly arrived immigrant personified the threat of trachoma.”²⁷

Trachoma was blamed on many of the nationalities of the “new immigrants,” but above all, it was associated with East European Jews. Trachoma was a bacteriological stand-in for the perceived threat to society that unrestricted immigration posed to the United States and its citizens. Immigrants not only brought with them the germs for dangerous, blinding diseases, but the very conditions that cultured those illnesses. While germ theory offered a certain democracy

²⁵ Reed, “The Medical Side of Immigration,” 383.

²⁶ Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” 494.

²⁷ Howard Markel, “‘The Eyes Have It’: Trachoma, the Perception of Disease, the United States Public Health Service, and the American Jewish Immigration Experience, 1897-1924,” *Bulletin of the History of Medicine* 74, no. 3 (2000): 536.

in which every human body was equally vulnerable, in reality, medical and popular opinion still considered immigrants as vectors. Certain diseases were “symbols of the immigrants’ low condition, greater susceptibility to disease, and congenital ignorance of hygiene.”²⁸ These chronic diseases prevalent among those living in poverty became the major determinant of deportations from Ellis Island, rather than far more dangerous diseases like cholera and tuberculosis. In fact, nine out of ten of those diagnosed with trachoma at American ports and borders between the years of 1900 and 1905 were deported.²⁹

Immigrants were certainly linked to disease in the minds of nineteenth century Americans, and this was clear in the discussion of children’s health as well. Lawrence Gulick, a nationally-renowned physical education teacher who worked in the New York Public Schools, wrote a book in 1908 about medical inspection. He cited the changing “racial stock” of the nation as one of the causes for the need in increased medical inspection. “This is important because standards of living, of cleanliness, of freedom from vermin, are being brought in by recent immigrants which are not only different from those that obtained under early American conditions, but which are inimical to those higher standards of life that are essential to the individuals in a democracy that is to endure.”³⁰ Gulick, and no doubt many others, feared that the growing numbers of immigrant children would cause contagion and, indeed, were a threat to American standards.

The exclusion that occurred at the borders of the nation was being performed at another level of entry to the state: the school. The process of medical inspection, although ostensibly performed

²⁸ Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” 494.

²⁹ Howard Markel, “The Eyes Have It,” 531.

³⁰ Luther Halsey Gulick, *Medical Inspection of Schools* (New York: Charities publication committee, 1908), 7.

to help protect children from disease and plague, operated to keep certain—usually immigrant—children out of schoolhouses, thus denying them access to one of the benefits of citizenship. Since medical inspection made no effort to treat children, but simply kept them out of school to prevent contagion, it operated as a form of quarantine. The introduction of school nurses, then, counteracted the exclusionary effects of the medical inspection programs. School nurses transformed this policy of exclusion to one of inclusion; many of the diseases that came to be known as “immigrant diseases” eventually began to be regularly treated by school nurses, and children could continue to go to school.

School medical inspection focused on the spread of contagious disease rather than improving an individual child’s wellbeing. Led by Boards of Health, medical inspection had the goal of stopping epidemics by identifying which children had a disease while still in its early stages, and keeping those children in isolation from others. The primary decision they were to make was whether or not to bar the children from school.³¹ They focused on schools not because of a commitment to education, but because they viewed them as petri dishes. Dr. Charles Dewey of Boston described the conditions in schoolrooms that cultivated illness. “Here the children, at the most susceptible age, are brought into the closest relations. The schoolrooms are usually overcrowded and often poorly ventilated; the children’s outer garments are hung so closely together that they touch those of other children; they often use the same cups for drinking and sometimes the same towels, and during intermissions their games bring them into personal contact with other children from all parts of the school’s district.”³²

On March 16, 1897, the New York City Board of Health appointed 150 medical inspectors to work in the city, under the direction of Dr. A. Blauvelt, who previously held the

³¹ Dewey, “Medical Inspection of Schools in Boston,” 651.

³² Ibid., 650.

position of Assistant Chief of the Bureau of Contagious Diseases.³³ In its first year, these doctors performed 108,628 inspections and excluded 6,829 children from school.³⁴ All other benefits that came with school medical inspection by doctors were merely perks; namely, children were brought into contact with physicians who could point out a problem so that parents might seek out treatment. Although some students did benefit from the inspection by having illnesses that needed to be referred to private physicians identified, for the most part, those pupils who could not afford care did not receive it.

In 1901, Dr. S. Josephine Baker took the civil service examination and was appointed a medical inspector for the health department. Dr. Baker called medical inspection at that time a “pathetic farce.”³⁵ There were 150 doctors who worked in the schools for one hour a day, and in that hour, they had to visit three or four schools. Doctors asked teachers to refer any student who did not seem well, and then made a superficial exam and sent him home if there was any suspicion of contagious disease. No diagnosis was made. Some medical inspectors never showed up at their schools at all, and simply telephoned each morning. Baker found the administration at that time to be so corrupt and useless that she was ready to quit. Historian John Duffy agreed: “Whatever the case, the Tammany regime from 1898 to 1901 was one during which the Health Department at best marked time.”³⁶

Reform candidate Seth Low was elected mayor in 1902, and he helped to transform the health department into an efficient machine.³⁷ Medical inspectors were paid more, worked three hours a day, and were to inspect all children routinely instead of just those referred by teachers.

³³ Gulick, *Medical Inspection of Schools*, 24.

³⁴ Wald, “Medical Inspection of Public Schools,” 90.

³⁵ Baker, *Fighting for Life*, 56.

³⁶ John Duffy, *A History of Public Health in New York City, 1866-1966* (New York, Russell Sage Foundation, 1974), 239.

³⁷ *Ibid.*, 252–253.

Low added more doctors to the staff so that every child could get a cursory examination. Politely remarking on the sudden change in the process of medical inspection, the Superintendent of Schools, William H. Maxwell, wrote in his *Annual Report to the Board of Education* that medical inspection “has been prosecuted by the President of the Department of Health ... with much greater vigor and thoroughness than in former years.”³⁸

This is what Baker would call the second phase of medical inspection, which added routine inspection to the program—the deliberate seeking out of contagious diseases that might not have been obvious or harmful enough to warrant staying home from school, and were often so persistent that they were considered normal conditions rather than as illnesses. The Superintendent noted the difference between this period and that of the Tammany regime. Under Low, “the exclusion of children who were suffering from dangerous contagious diseases was vigorously insisted upon.” He agreed that some diseases—he noted trachoma—indeed required serious action, but also remarked on an “excess of zeal.” “Great numbers of children were excluded, however, for diseases which, while doubtless contagious under certain circumstances, are not at all serious in their nature.”³⁹

The method for the periodic inspection used in schools was to parade the students past the doctor in the classroom. Although it was a very superficial examination, it did provide the necessary information for exclusion from school. Dr. Baker, too, established her own version of the medical gaze and could quickly diagnose on the line. After some experience, she could make some determinations on the child’s health “almost as soon as the door was opened and before the

³⁸ Department of Education The City of New York, *Fourth Annual Report of the City Superintendent of Schools to the Board of Education for the Year Ending July 31, 1902*, 1902, 112, Micro. Cab. Roll 14, New York, City Hall Library.

³⁹ Ibid.

children passed before me.”⁴⁰

The degree of illness was overwhelming, and medical inspectors were “literally depopulating the schools.”⁴¹ At times, ten to twenty percent of the school’s population was excluded because of a disease or “defect.”⁴² Inspectors sent home any child with a contagious eye or skin disease: 80 percent of the children were diagnosed with pediculosis (head lice), while 20 percent had trachoma. Skin diseases like scabies, ringworm, and impetigo were rampant. As Dr. Baker wrote, “Those were not schoolrooms we inspected; they were contagious wards with all the different diseases so mingled it was a wonder that each child did not have them all. Many of them did: lice, trachoma, scabies, ringworm, all at once.”⁴³ The classrooms were so deserted that it alarmed the truant officers, who then started making the rounds to order the children back to school.⁴⁴

Reformers were appalled at the inanity of the situation. Lillian Wald, of the Henry Street Visiting Nurse Association, remarked on the limitations of such medical inspection, saying that it “proved to be a perfunctory service that only superficially touched the needs of the children.”⁴⁵ Medical inspectors did not diagnose or treat children, nor did they share information on how to prevent getting sick in the first place. Wald was shocked to see those same children who were sent home from school outside in the streets in the evening, “playing with the children for whose protection they had been excluded from the classrooms.”⁴⁶

The President of the Department of Education and the new health commissioner, Dr.

⁴⁰ Baker, *Fighting for Life*, 78.

⁴¹ Ibid.

⁴² Rogers Struthers, *The School Nurse*, 16.

⁴³ Baker, *Fighting for Life*, 79.

⁴⁴ Ibid., 79–80.

⁴⁵ Wald, *The House on Henry Street*, 49.

⁴⁶ Ibid., 50.

Ernst Lederle, whom Lillian Wald called “an intelligent friend of children,” sought out Wald for guidance. She decided the time was right to “urge the addition of the nurse’s service to that of the doctor.” She would supply a nurse from her settlement for one month at no cost, and in that time she would demonstrate that with the addition of a nurse the students would not lose so much time from school. She insisted, however, that if the experiment were successful, they should pay the nurses through public funds, as the doctors were paid.⁴⁷

Lillian Wald chose Lina Rogers, whom Wald said was “an experienced nurse” who “possessed tact and initiative,” from among her settlement staff to be the first school nurse in the United States. “With the equipment of the settlement bag and, in some of the schools, with no more than the ledge of a window or the corner of a room for the nurse’s office, the present system of thorough medical inspection in the schools ... was inaugurated.” The experiment was considered a success, and the city did agree to pay for the employment of nurses, “the first municipalized school nurses in the world.” For Lillian Wald, “this marked the beginning of an extraordinary development of the public control of the physical condition of children.”⁴⁸ In

⁴⁷ Ibid., 51. What she wrote exactly was “*Reluctant lest the democracy of the school should be invaded by even the most socially minded philanthropy*, I exacted a promise from several city officials that if the experiment were successful they would use their influence to have the nurse, like the doctor, paid from public funds.” There are several ways to read this. The most apparent is that she did not want the school to be influenced by private organizations, and that the school should indeed be completely public. This could prevent, I imagine, other religious institutions with visiting nurse services from entering the schools, since her own settlement house was established so that the Jewish poor did not have to go through churches to get aid that carried certain stipulations. Or this statement could reflect recent educational reforms meant to diminish the influence of politics. Most importantly, I think this statement reflects a commitment from Wald and others that the city government should take responsibility for the health of children. Finally, for nurses as a profession, it opened up the possibility for a professional service that was funded by the state and not by private associations. School nursing created a whole new specialty in the field of public health nursing, and thus a far more independent nursing service than those nurses attached to doctors or hospitals.

⁴⁸ Ibid., 52–53; Wald wrote other accounts in journals and articles. Lillian D. Wald, “The School Nurse in New York City, in Official Reports of Societies,” *The American Journal of Nursing* 3,

December of 1902, Lina Rogers was given the new office of Superintendent of School Nurses, and twelve assistant school nurses were hired. In January, the Board of Estimate and Apportionment made an appropriation of \$30,000 to add more nurses, and by February of 1903, just a few months after the initial experiment, there were 27 nurses on the staff.⁴⁹

The presence of school nurses rapidly changed the policy of medical inspection.⁵⁰ In the 1903 Annual Report, the Department of Health wrote that the intention of the new system of medical inspection was “not merely to exclude children” but “to secure their prompt treatment and return.”⁵¹ This was a dramatic turnaround. The Superintendent was very pleased with the addition of school nurses. In the report that year, he introduced the concept of the school nurse, “whose duty it is to treat children suffering from mildly contagious diseases as soon as the ailments are discovered, so that such pupils can return to their class-rooms immediately. These nurses also visit homes and explain to parents the nature of their children’s physical troubles, with the result that children are no longer kept out of school for days and weeks for causes which may be remedied in a few moments by a skillful nurse.”⁵²

Lina Rogers was indeed a thorough and inventive nurse, who was very sensitive to the physical

no. 3 (December 1902): 221–222; Wald, “Medical Inspection of Public Schools.” Lavinia Dock also wrote on the promise of school nursing. L.L. Dock, “School-Nurse Experiment in New York,” *The American Journal of Nursing* 3, no. 2 (November 1902): 108–110.

⁴⁹ Rogers Struthers, *The School Nurse*, 27.

⁵⁰ Lina L. Rogers, “A Year’s Work for the Children in New York Schools,” *The American Journal of Nursing* 4, no. 3 (December 1903): 101.

⁵¹ *Annual Report of the Department of Health of the City of New York for the Calendar Year 1903* (New York City Department of Health, 1903). Excerpted in Robert Hamlett Bremner, *Children and Youth in America: A Documentary History* (Cambridge, Mass: Harvard University Press, 1970), 906–907.

⁵² Department of Education The City of New York, *Fourth Annual Report of the City Superintendent of Schools to the Board of Education for the Year Ending July 31, 1902*, 112.

and social needs of children.⁵³ Her activities reflect a significant shift in the way public health was approached at the turn of the century: through prevention rather than cure and through treatment rather than quarantine. Education and prevention were the key words of reformers who sought to engage social problems, and those words were also employed in a discussion of how public health measures should be carried out. Rogers put forth a strong vision of what the goals of the school nurse should be in relation to the treatment of the child, the positive relationship to the family, and the school's responsibility toward both the mental and physical health of

⁵³ Rogers wrote throughout her career about school nursing in the United States and Canada, and gave conference papers throughout the world. Rogers, "A Year's Work for the Children in New York Schools"; Lina L. Rogers, "School Nursing in New York City," *The American Journal of Nursing* 3, no. 6 (March 1903): 448–50; Lina Rogers, "Letter to the Editor of Charities: The Public School Nurse," *Charities and the Commons* 15, no. 2 (October 14, 1905): 106–7; Lina L. Rogers, "The Nurse in the Public School," *American Journal of Nursing*, August 1905; Lina L. Rogers, "The Physician and the Nurse in the Public School," in *Proceedings of the National Conference of Charities and Correction*, 1905, 273–80; Lina L. Rogers, "Nurses in the Public Schools of New York City," *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance* 16 (April 7, 1906): 65–69; Rogers, Lina, "Nurses in Public Schools," *The Canadian Nurse* II, no. 1 (March 1906): 33–34; Lina L. Rogers, "Some Phases of School Nursing," *The American Journal of Nursing* 8, no. 12 (September 1908): 966–74; Lina L. Rogers, "Summer Care of Babies in New York City," *The American Journal of Nursing* 8, no. 12 (September 1908): 1000; Rogers, Lina, "Medical Inspection of Schools, Proceedings of the Annual Meeting of the Graduate Nurses' Association of Ontario, Held in the Residence of the Sick Children's Hospital, on Tuesday, May 24th, 1910," *The Canadian Nurse* VI, no. 8 (August 1910): 334–36; Lina L. Rogers, R.N., "What the Public School Nurse Is Doing," *The Visiting Nurse Quarterly* 2 (1910): 14–18; The Canadian National Association of Trained Nurses, "School Nurse in Toronto," *The Canadian Nurse* VI, no. 6 (June 1910); Lina L. Rogers, "School Nursing in Toronto, Canada: First Paper," *The American Journal of Nursing* 12, no. 1 (October 1911): 19–22; Lina L. Rogers, "School Nursing in Toronto, Canada: Second Paper (Continued)," *The American Journal of Nursing* 12, no. 2 (November 1911): 105–10; Lina L. Rogers, "School Nursing in Toronto, Canada: Third Paper (Continued)," *The American Journal of Nursing* 12, no. 3 (December 1911): 206–9; Lina L. Rogers, "School Nursing in Toronto, Canada: Fourth Paper (Continued)," *The American Journal of Nursing* 12, no. 4 (January 1912): 303–17; Rogers, Lina, "School Nursing," *The Canadian Nurse and Hospital Review* VIII, no. 7 (March 1912): (366–367); Rogers, Lina L., "School Nursing in Toronto, Canada (Read at International Congress of Nurses, Cologne, Germany)," *The Canadian Nurse and Hospital Review* VIII, no. 10 (October 1912): 539–44; Lina Rogers Struthers, R.N., "Nursing Side of Medical Inspection of Schools," *Canadian Journal of Public Health* 4, no. 4 (1913): 147–48; Rogers Struthers, *The School Nurse*.

children.

Before the nurse's arrival at her school, the doctor had already made his inspections on his daily round.⁵⁴ Rogers showed up at her first school at 9am and reported her arrival to the principal, who then notified the teachers to send down the students that the inspector had selected. She proceeded immediately to the space that had been set aside for her and prepared her clinic. Students were then sent down to her to be treated. Afterwards she put away her supplies and went to the next school. In 1903, each nurse was assigned an average of four schools; she spent between 60 and 90 minutes at each location.

A new record-keeping system was also put in place to help keep students from being lost in the shuffle between the various parties now working with the children. Under the previous medical inspection, the doctors did record information on a card, but then this was sent home to the parents "and when it was needed it could not be found." Now the cards contained additional information, such as "dates, when ordered under treatment, exclusion, readmission, and also the class and room number and school." It also had the coded number circled. This card was "signed by the Medical Inspector and left on file for the use of those requiring this information."⁵⁵ This system would become more elaborate over time, and would include a complete record of the child's health from kindergarten to leaving school. These cards were the main means of communicating between the doctors and the nurses, who did not usually work together.⁵⁶ Many

⁵⁴ Rogers, "A Year's Work for the Children in New York Schools," 182.

⁵⁵ Ibid.

⁵⁶ Although there are photographs of S. Josephine Baker and Lina Rogers both inspecting children simultaneously, from the reports that describe how medical inspection and school nursing occurred, this must have been a staged event.

of the reports and manuals that were distributed had forms they required of their employees, but they also served as templates for other departments to emulate.⁵⁷

There were common diseases that nurses met with that are now practically unknown in the United States. While today's school nurses measure the growth and development of children, test their eyes and ears, and handle minor illnesses, bumps and bruises, these school nurses dealt with a variety of infections and pests that make the modern reader's skin crawl. Bacterial and fungal infections and parasitic infestations were common: scabies and ringworm, trachoma and conjunctivitis, head lice and favus were among the ailments that students regularly contracted. Nurses still had to contend with some of the major child killers before public health prevention policies were implemented and the widespread use of vaccination could be possible: poliomyelitis, scarlet fever, meningococcal meningitis, whooping cough, and diphtheria; mumps, German measles, chickenpox, and smallpox. Not to mention just a few of the other illnesses that were still striking adults and children alike: typhoid, tuberculosis and sometimes tetanus, leprosy, and rabies.⁵⁸

The first way to reduce the number of exclusions was through treatment of minor illnesses, which actually involved touching students, rather than just inspecting them. In 1903, the school nurse was only allowed to treat a few diseases: pediculosis, conjunctivitis, ringworm, impetigo, favus, molluscum contagiosum, and scabies.⁵⁹ Pediculosis, which affected four out of

⁵⁷ Rogers elaborated the entire system in her manual, complete with all of the various forms, as she had developed it by 1917. Rogers Struthers, *The School Nurse*, 263–292; S. Josephine Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, Monograph Series / Department of Health of the City of New York; No. 4; (New York: Dept. of Health of the City of New York, 1915). An example of the index card can be found on page 112.

⁵⁸ New York (N. Y.). Board of Health, *Annual Report of the Department of Health of the City of New York for the Calendar Year 1921* (New York: New York Print. Co., 1922).

⁵⁹ *Annual Report of the Department of Health of the City of New York for the Calendar Year 1903*.

five students in Rogers' schools, was the first problem to tackle. Most families had never considered head lice a serious problem, but rather a pesky but ordinary condition. Josephine Baker described the condition as "that ever present scourge of school life."⁶⁰ She recalled seeing "the lines of little girls with their pigtailed pulled forward over their eyes so that the nurse could look through her hair."⁶¹

Nurses treated the problem in school. While inspection might just require a couple of toothpicks to poke through the hair lightly, nurses had to thoroughly handle the heads of students to treat lice. First, the nurses wanted to kill the hatched lice that were present by massaging the child's head with a mixture of equal parts kerosene and olive oil until the hair was thoroughly saturated. They tied the hair up overnight, and the student would then have to return to the nurse the following morning to get the oil rinsed out with a solution of potassium carbonate and then soap and water. The nurse would then have to carefully tease out the nits, or eggs, with a fine-tooth comb. Hot vinegar worked to loosen the glue on the nits and to help them be pulled from the strand of hair on a second comb-through.⁶² Rogers wrote: "Sometimes it is most difficult to destroy the ovae or nits. Saturate the hair with hot vinegar and again comb carefully. Or the ovae may have to be pulled off one at a time."⁶³ And through all of this, sometimes the process would still fail and would have to be repeated. This was indeed a tedious treatment that required knowledge and commitment to complete, along with some gentleness, one hopes, and certainly differed from the previous reaction of medical inspectors, which was to remove children from school and then wonder why they never came back. Even with the frequency and persistence of

⁶⁰ S. Josephine Baker, "Health Leagues as an Aid in School Medical Inspection," *Public Health Nurse Quarterly* VII, no. 3 (July 1915): 47.

⁶¹ Baker, *Fighting for Life*, 80–81.

⁶² Rogers, "A Year's Work for the Children in New York Schools."

⁶³ Rogers Struthers, *The School Nurse*, 171–172.

pediculosis, nurses kept the majority of cases in class. In 1909, there were 151,585 cases of pediculosis found in all of the schools of New York City, but only 2,014 were excluded for this reason.⁶⁴

Nurses addressed some eye conditions, but not all. In 1903, trachoma was considered far too serious to allow the nurse to handle since cleanliness and care did not do much good once the infection had progressed. But once nurses were in place, the department finally took notice and brought trachoma under treatment; Dr. Lederle gained appropriations to hire specialists and to open a trachoma clinic in the east wing of Gouverneur Hospital on December 16, 1902. By June of 1903, 12,839 patients were treated for trachoma, 2,761 of which had to be operated on. The number of treatments continued at the same level, but new cases decreased. Many of the cases were returnees, since the infection was so difficult to treat.⁶⁵ The clinic was opened for less than two years, but by the time it closed “the disease was no longer epidemic among the children of the lower east side.”⁶⁶ A second trachoma clinic opened in Harlem around March 1904 that could address the needs of the Italian children in that neighborhood for whom the commute to Gouverneur had been too long.

The treatment for the non-operative cases of trachoma at the clinic was painful and prolonged. The eyes were anesthetized with a bit of cocaine. The child sat down on the “operation stool,” the nurse held back the head, and the doctor used a caustic “greenish pencil of sulphate of copper,” the preferred treatment for the “burning out” of the granules on the inside of the eyelid. This treatment had to be done “every day for several weeks, then every other day for a

⁶⁴ Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 105.

⁶⁵ *Annual Report of the Department of Health of the City of New York for the Calendar Year 1903*.

⁶⁶ “The Fight Against Trachoma; What the Department of Health Has Done in Stamping out the Disease among Children of the Public Schools,” *New York Times*, September 11, 1904.

couple of months, then weekly for the rest of the year.” Even the operative cases required regular follow-ups.⁶⁷

The role of nurses added early detection and treatment and the better control of trachoma contagion.⁶⁸ In 1909, 45,916 cases of trachoma were found in NYC schools, but only 1,392 were kept out of school for this reason, which wasn’t much greater than the far less dangerous conjunctivitis (1,338 exclusions out of 49,807 cases found in schools).⁶⁹ And with this treatment, the number of cases of trachoma found in schools went down annually every year from 1909-1914, decreasing to a quarter of the original number, so that by 1914 there were only 11,214 cases, and of those, 131 exclusions.⁷⁰ Conjunctivitis, or as we know it, “pink eye,” is a contagious eye infection that spreads quickly. Nurses treated this with a boracic-acid solution, and then visited the homes of the infected children so that the mothers could learn and repeat the same procedure in regular treatments.⁷¹

Nurses treated skin conditions that previously would have been an excuse for exclusion from school. Lina Rogers wrote, “Instances have come under my own notice where children have been kept out of school for weeks with a slight eczema on the face or head, and after a few days’ careful treatment have been returned to school.”⁷² One can’t help but think of Louis Rifkin and the minor skin condition that kept him illiterate until he was twelve years old.

Ringworm and favus (ringworm of the scalp), both stigmatized as immigrant diseases,

⁶⁷ Ibid.

⁶⁸ Rogers, “A Year’s Work for the Children in New York Schools,” 183; “The Fight Against Trachoma; What the Department of Health Has Done in Stamping out the Disease among Children of the Public Schools”; Duffy, *A History of Public Health in New York City, 1866-1966*, 254–255.

⁶⁹ Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 105.

⁷⁰ Ibid.

⁷¹ Rogers, “A Year’s Work for the Children in New York Schools,” 183.

⁷² Rogers, “School Nursing in New York City,” 450.

received some simple treatments such as a good scrubbing with tincture of green soap, and maybe the application of an antiseptic like iodine, before covering with a bandage. In the case of favus, epilation was required. Tweezing hair out of a crusty scalp does not sound pleasant for either the nurse or the child, but the daily treatment of these skin conditions healed these cases and a bandage helped to contain the spread to other children.

By 1921, the Department of Health would call many of these illnesses a remnant of the past, and credit the results to school nursing. “The contagious eye and skin diseases, formerly so common among school children, practically have been eliminated. Trachoma, ringworm, scabies, impetigo and other common forms now are unusual. This remarkable reduction in incidence of these conditions and resultant improved health of the children are due to the work of school nurses.”⁷³ Most importantly, these diseases—so commonly linked to immigration and stigmatized as evidence of degradation and squalor—were treated and ultimately nearly eliminated.

School nurses sometimes had to use the inspection line, but they were sensitive to both the dignity and privacy of their young patients. Lina Rogers advised other nurses that when routine inspection was done in the classroom, they should request that students come one row at a time, and that if possible it should occur at the rear of the room. “Have the teacher insist that the pupils in the seats do not sit staring at those being examined,” she urged in her handbook.⁷⁴ Any children who needed additional instruction or treatment were asked to come to the nurse’s station—such as it was—to be addressed individually. There “such instruction is given or examination of the pupil is done in private.” To be very clear, she further defined the meaning of

⁷³ New York (N. Y.). Board of Health, *Annual Report of the Department of Health of the City of New York for the Calendar Year 1921*, 112.

⁷⁴ Rogers Struthers, *The School Nurse*, 59.

privacy as “no one else being present.”⁷⁵

The nurses also used codes for diagnoses in order to maintain privacy, even to the point of making a number system for each illness, so that if a student was sent home, the reason was kept secret. All children were given a number, regardless of their diagnosis. Nine and fifteen both signified “nothing,” “so that all might be given a number and no distinction made.” Pediculosis was given four separate codes: “Numbers 2, 4, 6,8 were given to avoid hurting the feelings of any children who might discover what the first number meant.”⁷⁶ While the chalk-written symbols on the Ellis Island line were a secret language between inspectors, the codes in the schools were for privacy.

Rogers insisted that the feelings of children be protected, especially with head lice. “There is no excuse for a nurse examining a child’s head for pediculi in the presence of other children, or even a teacher, no matter what kind of home he comes from.”⁷⁷ When the prevalence of pediculosis required the examination of every child, she said that a screen should be placed in the corner of the classroom so that they could be inspected one at a time. Although this emphasis on privacy regarding pediculosis could have contributed to a feeling of shame about a condition that many considered normal, the nurse did not connect the disease with the “lowly condition” of the immigrant in a way that a public health inspector at Ellis Island might have. As Lillian Wald put it, “A routine was devised, and the examining physician sent daily to the nurse all the pupils who were found in need of attention, using a code of symbols in order that the children might be spared the chagrin of having diseases due to uncleanness advertised to their associates.”⁷⁸

⁷⁵ Lina Rogers Struthers, R.N., *The School Nurse* (New York and London: G.P. Putnam’s Sons, 1917), 65.

⁷⁶ *Ibid.*, 26.

⁷⁷ *Ibid.*, 65.

⁷⁸ Wald, *The House on Henry Street*, 51.

There were, of course, some illnesses that were indeed dangerous and contagious and could lead to an outbreak—scarlet fever one of the more frequent—that the nurse could not treat at school.⁷⁹ When this occurred, the nurse visited the mother at home and personally urged a visit to a private physician, or took the child to the dispensary herself.⁸⁰ The medical inspector still focused on tracking down and reporting contagious diseases, which had always been their task as employees of a Board of Health that continued to find this a high priority. Under this modified system, the Medical Inspectors had to acquire the names and addresses of any children who missed several days of school and then visited their homes to verify if the children had a contagious disease, and if any members of the family had caught it as well. The Board of Health announced that by this means they were able zero in on those cases that they would not otherwise have tallied. For the medical inspectors, school children were still a means to identify and locate possible sources of contagion and quarantine them, as well as an opportunity for contact with families. School medical inspection was, then, still serving the same interests of the Board of Health as it had previously; it just expanded the Board's access.⁸¹

The distinction between what the school nurses and the medical inspectors were doing was a fundamental difference in how nurses and doctors understood and dealt with issues of health more generally, which has been characterized as “caring” versus “curing.”⁸² We can see this clearly in Lina Rogers' vision for the treatment of school children; Rogers, a Henry Street nurse, took social and family conditions into consideration the when treating the physical health

⁷⁹ Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 105–106.

⁸⁰ Wald, *The House on Henry Street*, 52–53.

⁸¹ *Annual Report of the Department of Health of the City of New York for the Calendar Year 1903*.

⁸² Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987).

of children. Doctors focused on the disease and the individual body, while the nurse provided for the entire well-being of the patient and his community.

Adele Shaw, in a December 1903 article for *The World's Work* that explored the deleterious conditions in New York City schools, remarked on the disparity between the doctors and nurses.⁸³ For Shaw, it was obvious that some of the doctors were merely “holding down their job.” But the quality of the school nurses was uniform, in contrast to the spotty commitment of the inspectors. “I met several sorts of school doctors, but only one kind of nurse,” she wrote. She wished that the Board of Health who appointed the inspectors would match the criteria that Wald and Rogers used to choose their nurses. The inspectors also had a much simpler job to do that in no way equaled the duties of the nurse. “As a rule,” she wrote, “the doctor’s toil is briefly over. The nurse’s lasts all day.”

She had followed two different physicians as they completed their medical inspections, one man and one woman (who very probably was Dr. S. Josephine Baker) and compared their level of thoroughness and commitment to the job. “The women seemed to be always hard at work and always favorites,” she wrote. While the male physician had “inspected for ‘head,’ ‘eyes,’ and ‘throat’ fourteen children” during his morning rounds, the female physician had seen a thousand. “Her cheeks were flushed with weariness, but by her promptness in getting the afflicted few under treatment she had saved many from contagion.”

Shaw very effectively used synecdoche here, since she strategically disclosed that the doctor saw his young patients as parts and tasks. Her terseness in the description of the medical inspectors also contrasted with the expanded descriptions she gave of the nurses, which not only showed more thoroughly what the nurse did, but also included dialogue between the nurse and

⁸³ Adele Marie Shaw, “The True Character of New York Public Schools,” *The World's Work*, December 1903.

her patients. The descriptions also revealed tenderness and attention. The nurse “soothe[d]” and “cared for”; she had “tact” and “humanity” as well as “firmness.”

According to Shaw, the children responded well to their treatments. “Not a child whined or begged off, and not one cried out at the smart. The thing that goes straight to one’s heart is the satisfied and utter confidence with which they settle back into the nurse’s hands. They *like* to be cared for. ‘Did your big sister use the kerosene?’ asked the nurse, parting a mop of hair to peer carefully at the forest within. ‘Yes, ma’am,’ replied the afflicted one. ‘Tell her to put on more, so it will soak all through, and come to me tomorrow,’ was the day’s direction.”

These were precisely the kind of interactions that one would expect from a Henry Street nurse. We have seen how Lillian Wald had argued for the dignity of her patients, and it was clear that Lina Rogers brought this humane treatment into schools, and then instituted it as Superintendent of Nurses and in her training and establishment of school nursing programs in other parts of the United States. But it must be said that not all children recalled such delicate treatment from their nurses. Catharine Brody remembered her school inspections to be a “necessary procedure” but a humiliating experience. “The chief thing, beyond all marks and studies, was to be clean and to have a clean head. It was a praiseworthy idea, but engineered with such lack of tact as to bring torture and tears to children penalized for the ignorance of their parents.” The nurse was described as a “white presence,” who instead of treating the children with privacy and dignity, called them up in small groups in front of the whole class; children were mortified if they were among those with nit-ridden napes. Those so affected were “sent to

Coventry,” a social ostracization that was enforced with seats in the back of the classroom, as well as at the end of the recess line.⁸⁴

More and more health services were added for school children. On March 27, 1905, services were expanded to include a “complete physical examination of each school child.”⁸⁵ This was a result of studies done by the Bureau of Municipal Research in 1903 and 1904 that showed that large percentages of children suffered from spinal curvature and defective vision.⁸⁶ Instead of the doctor performing the routine medical inspections, the nurse did so, and then sent the cases that needed further aid to the doctor afterwards for confirmation of diagnosis.⁸⁷ That way, the doctors could focus on the physical examinations. Dr. Baker explained the extent of these exams:

“condition of nutrition, presence of enlarged glands, chorea, cardiac disease, pulmonary disease, skin disease, deformities of spine, chest or extremities; defective vision, defective hearing, deficient nasal breathing, defective teeth, deformed palate, hypertrophied tonsils, posterior nasal growth [adenoids], deficient mentality, and finally whether, in the inspector’s opinion, treatment is necessary.” Baker argued that “the figures speak for themselves.” In the first three months of

⁸⁴ Catharine Brody, “A New York Childhood,” *The American Mercury: A Monthly Review*, May 1928. Brody wanted to write the stories of a New York childhood from a girl’s perspective, which she felt had been untold, since the rest were “invariably devoted to the doings of boys.” She said she was writing about twenty years previously, which would have put her in New York around 1908, a child of immigrant Orthodox Jews.

⁸⁵ Baker, S. Josephine, “The Medical Inspection and Examination of School Children in New York City,” *Annals of Gynecology and Pediatrics* 19, no. 8 (August 1906): 441–51.

⁸⁶ *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research* (New York: Bureau of Municipal Research, 1908), 8.

⁸⁷ Rogers, R.N., “What the Public School Nurse Is Doing,” 16.

1906, 24,000 received complete examinations, and 2/3 of them were recommended for treatment.⁸⁸

Since almost all of the ailments that these children suffered from were “remediable,” there needed to be a system for notifying the parents. At first, these notifications were just sent home with the child in an envelope, but later inspectors began a system of sending postcards to parents about their child’s health. It included a reply postcard, so that once a doctor saw the child, he could send it in to notify the Health Department that the pupil was under treatment.⁸⁹

That said, even with the sheer numbers who needed further treatment for some physical abnormality, Dr. Baker argued that only a small percentage actually had parents who complied with the recommendations. Therefore, even though the schools had a record of the state of the child’s health, “the records soon amount to little more than the mere compiling of statistical data unless some definite and systematized effort be made to see that the children obtain proper medical care.”⁹⁰ The Bureau of Municipal Research followed up with a study on the best means to get parents to act. Administrators had assumed that parents didn’t treat their children because they were simply resistant to intrusion or plain negligent; it turned out, once nurses were added to the process, many parents did as requested. The inspector still sent home his postcard, but then the nurse also received notification of the child’s abnormality and visited the parents at home a few days later to explain the necessity of care. The nurse was able to find out what was keeping parents from acquiring the treatment. If it was due to cost, she recommended a dispensary. If the dispensary was difficult to attend because of the hours parents worked, the nurse took the child

⁸⁸ Baker, S. Josephine, “The Medical Inspection and Examination of School Children in New York City.”

⁸⁹ *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research*, 9.

⁹⁰ Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 99.

to the dispensary herself. Under this system, only 4.2% of parents refused to act.⁹¹ In 1908, the Bureau of Child Hygiene was established, with Dr. Baker at its head. The staff of nurses was greatly increased, and therefore they had time not only to visit the sick children, but to go the homes of those children with some other abnormality, such as defective vision or teeth, or enlarged adenoids or tonsils, that parents needed more persuasion to correct.

These physicals drew attention to chronic concerns that weren't previously addressed by school health. Like medical practitioners, teachers were on the lookout for conditions that might affect a student's learning. Suddenly there was a lot of concern focused on the noses and throats of children; in particular, both teachers and nurses were increasingly concerned with adenoids and tonsils. There were two prominent clues that adenoids were causing problems for a child: one was behavioral, and the other was physical. If a child breathed through his mouth rather than his or her nose, as evidenced by having the mouth hanging open, that was a good sign that the child was having difficulty breathing through the nose. Children with adenoid problems also had malocclusion, or a "lower jaw thrown slightly forward."⁹² The growth behind the nose forced the facial bones forward to make room, but keeping the mouth open also changed the structure of the jaw and palate, since the tongue needs to be pressed on the roof of the mouth to help it develop properly and to make room for the teeth.

"Mouth breathers" got a bad rap as being dull and slow. Part of this was due to the sluggishness that the difficulty in breathing caused students, especially since it also hindered their ability to sleep. Educators were worried about adenoids because they believed that the

⁹¹ *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research*, 20.

⁹² Rogers Struthers, *The School Nurse*, 198.

inability to breathe through the nose meant that children weren't getting enough oxygen, causing lethargy, backwardness, and possibly "feeble-mindedness."

But while many had blamed mouth breathing on bad habits, Lina Rogers was careful to say that "no child ever becomes a mouth-breather as long as he can breathe easily through his nose." She explained that the cause of mouth breathing was the growth of tissues in the nose that interfered with breathing. She wrote, "Mouth breathing cannot be stopped by simply telling the child to keep his mouth shut, and any attempt to enforce this command is ignorant cruelty."⁹³ Whatever the cause, the only solution was to remove the nasal blockage. Rogers argued that once the adenoids were removed, there would be dramatic improvement for the child. "The change from dull, slow, colorless, stupid-looking boys with discharging noses, sleepy eyes, round shoulders, contracted chests, and puny bodies, to alert, erect, active, clean, bright-eyed, intelligent boys is a striking picture not soon forgotten."⁹⁴

In Myra Kelly's short story, "The Slaughter of the Innocents," Kelly's alter ego Miss Constance Bailey, a school teacher, was on the lookout for certain symptoms related to adenoids.⁹⁵ "At recess time Teacher detained the small sufferer and made a superficial examination. A shade of fever, a general sense of *malaise*, a great weariness without much desire to sleep, a persistent headache, a little difficulty in hearing, almost bloodless gums and inner

⁹³ Ibid., 194.

⁹⁴ Ibid., 199.

⁹⁵ Myra Kelly wrote fictionalized stories from the perspective of a teacher in the Lower East Side based on her own experience working in New York City schools. Her first published story appeared in McClure's and her first book, a collection of short stories, *Little Citizens: The Humors of School Life* came out in 1904, and was followed by *Wards of Liberty* (1907) and *Little Aliens: A Continuation of Little Citizens* (1910). These books presented a sympathetic if somewhat distorted and patronizing view of immigrant children in the East Side. Her books sold very well and made Myra Kelly a brief success in the literary world until her death from tuberculosis in 1910 at the age of 34. Myra Kelly, *Little Aliens* (New York: C. Scribner, 1910); Myra Kelly, *Little Citizens; the Humours of School Life* (New York: McClure, Phillips & Co, 1904); Myra Kelly, *Wards of Liberty* (New York: The McClure company, 1907).

eyelids, were the symptoms at which she arrived.”⁹⁶ She was so concerned because these symptoms were also linked with failure in school. “‘Really, do you know,’ Miss Bailey commented, ‘I think there is some subtle connection between their noses and their brains. I’ve noticed a decided improvement in the youngsters who have received treatment.’”⁹⁷

The school nurse took on greater responsibilities as time went on. In order to prevent the duplication of work, starting January 1, 1912, the Bureau of Child Hygiene added contagious cases to the school nurse’s responsibilities. This left the medical inspector to perform the annual physicals. This increased responsibility showed trust in the school nurses, who previously had not been allowed to handle contagious cases and had to report these directly to the medical inspector. It also revealed a greater interest in and commitment to the physical examinations that recorded all aspects of a child’s physical health in a systematized way, rather than just when a child got sick.

The Department of Health continued to expand both the number of children it served and the type of services that it provided. By 1914, doctors also inspected parochial schools and all children in public institutions such as orphanages and juvenile detention centers. Between 1909 and 1912, there were substantial reductions in defective vision, nasal breathing problems associated with adenoids, and in swollen tonsils.⁹⁸

This was further improved when, in 1912, the Department of Health added six clinics to provide services for children who could not otherwise afford medical attention. These clinics provided eye examinations for the prescribing of glasses, treated eye diseases, and removed

⁹⁶ Kelly, *Wards of Liberty*, 96–97.

⁹⁷ *Ibid.*, 102.

⁹⁸ Ernst J. Lederle, “Four Years in the Department of Health,” *Department of Health of the City of New York Reprint Series 1913- 1915*, no. 14 (1914): 9.

adenoids and tonsils. (The Commissioner of Health emphasized that while some dispensaries had been performing their adenoid removal surgeries without any anesthetic and turned students out that same day, the school clinics used a general anesthetic as a policy.) In 1913, six dental clinics were added.⁹⁹ These medical and dental clinics were placed in areas of the city where there were limited services of this type, and there was always a waiting list.¹⁰⁰

While the Bureau of Child Hygiene was adding additional services to the menu for children, they were still keeping private physicians involved in the care of children. By 1915, there was more effort made to have the families engage a private physician for the treatment of their children. According to Section 163 of the Rules and Regulations of the Bureau of Child Hygiene: “Every effort must be made, primarily, by the inspector and nurse to refer those children who require treatment to a private family physician. If there be no private family physician, and, if, furthermore, the family be unwilling or unable to employ such private family physician, the child may then be referred to the dispensary or school nurse.”¹⁰¹ By the time Dr. Baker published her report on the procedures of the Bureau of Child Hygiene in 1915, it seems that nurses were treating fewer conditions within the school. There were various forms and circulars that were to be sent home to the parents with instructions for their particular malady—Form 18K-1914 Instructions to Parents on the Care of Children’s Hair and Scalp; Form No.115K Instructions to Parents Regarding Trachoma—and then the nurse confirmed “evidence of treatment” rather than performing those treatments on the child herself.¹⁰² If the parents demonstrated “persistent neglect,” only then would the nurse make a home visit and explain the

⁹⁹ Lederle, “Four Years in the Department of Health.”

¹⁰⁰ Ibid., 9.

¹⁰¹ S. Josephine Baker, *Rules and Regulations and Methods of Procedure of the Bureau of Child Hygiene* (New York: Bureau of Child Hygiene, 1915), 145–146.

¹⁰² Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 107.

necessity of their child's care. If parents still did not follow through, the child would be excluded.

The school nurse is a reflection of that belief that the state should take on a bigger role in the lives of its citizens, and that health care should be a part of that responsibility. Both Morris Berger and Allen F. Davis demonstrated that settlement houses aimed to be testing grounds for experimental projects that reformers hoped would ultimately come under the state's domain.¹⁰³ The school was the agency that they most hoped would take over these projects when they proved successful.

The central state agency in the lives of children was that of the school, which in many cases was also the point of entry into the entire neighborhood. How reformers viewed the school was fundamental to their general vision of the role of the government in the lives of children. Settlement workers and other progressives all shared the belief that education was the only way to alleviate the social problems that were plaguing the cities. Reformers were influenced by the ideas of William James, John Dewey, and G. Stanley Hall, who put increasing faith in early education as the time to reach children.¹⁰⁴ Jacob Riis wrote in *Children of the Poor* in 1892 that if there were more kindergartens there would be fewer prisons.¹⁰⁵ The necessity of the school

¹⁰³ Morris I. Berger, *The Settlement, the Immigrant, and the Public School* (Unpublished PhD Dissertation, Columbia University, 1956); Allen Freeman Davis, *Spearheads for Reform; the Social Settlements and the Progressive Movement, 1890-1914*, Reprint (New York: Rutgers University Press, 1984); Diane Ravitch, *The Great School Wars, New York City, 1805-1973: A History of the Public Schools as Battlefield of Social Change* (New York: Basic Books, 1974), 167. As Diane Ravitch put it, for these new progressive educators, "The school was charged with responsibilities which previously belonged to the family, the settlement house, and the community. Its functions were expected to expand to include 'direct concern for health, vocation, and the quality of family and community life.'"

¹⁰⁴ Alice Boardman Smuts and Robert W. Smuts, *Science in the Service of Children, 1893-1935* (New Haven: Yale University Press, 2006).

¹⁰⁵ Jacob August Riis, *The Children of the Poor* (Scribner's sons, 1892), 181.

was not taken for granted at the time that reformers were looking to add healthcare to the list of the school's responsibilities. The fight for compulsory education was difficult and ongoing, and it was especially so when paired with the powerful forces opposing child labor laws. Reformers sought to gain compulsory education laws to keep children in school, and especially to keep them out of workplaces.¹⁰⁶

In part, this was a result of the changing role of the child in the culture at large. Progressive reformers were shifting focus from the adult to changes that could be made in childhood, because they met with better success. Lina Rogers wrote that programs that focused on adults had failed to make any impact. But “when the maximum efforts were directed to the physical development of the child, to the preservation of health, and protection from disease, to instruction in personal hygiene and cleanliness, to child games and playgrounds, to the production of healthy, robust childhood, pessimists became optimists, and permanently higher standards of life and conducts seemed to be a reasonable possibility.”¹⁰⁷

Just as schools began to throw open their doors to more students through compulsory education laws, they began to expand their services beyond the regular school day. The introduction of the school nurse was a part of a broader project to make the school responsible for a greater part of children's needs other than simply the basics of reading, writing and

¹⁰⁶ “The best child-labor law,” Florence Kelley wrote in 1905, “is a compulsory education law covering forty weeks of the year and requiring the consecutive attendance of all the children to the age of fourteen years. It is never certain that children are not at work, if they are out of school.” Florence Kelley, *Some Ethical Gains through Legislation* (New York; London: Macmillan & Company, 1905), 96. Walter I. Trattner, *Crusade for the Children: A History of the National Child Labor Committee and Child Labor Reform in America* (Quadrangle Books, 1970); Kathryn Kish Sklar, *Florence Kelley and the Nation's Work* (New Haven: Yale University Press, 1995); Rosenberg, *Child Labor in America*; Florence Kelley, *Modern Industry in Relation to the Family, Health, Education, Morality*, (New York: Longmans, Green, and Co., 1914).

¹⁰⁷ Rogers Struthers, *The School Nurse*, 13–14.

arithmetic. Schools were looking to provide not only a wider set of educational services, including vocational education, homemaking, and other skills, but also to provide a space for play and leisure, especially in those neighborhoods in the city where many children had neither the space nor time to play; many spent their days in cramped workshops only to come home to equally cramped tenement flats. Vacation schools, playgrounds, and recreational centers were all a way to provide additional services meant to benefit the health and wellbeing of the city's poorest schoolchildren.

Julia Richman was one of the women who actively worked to change the role of the schools in the individual lives of children and in the community, expanding services and curricula to meet the needs of immigrants. Richman was born of German- Jewish immigrant parents, and was a teacher, principal, and school superintendent on the Lower East Side from 1898 to 1912. Richman was connected with the circle of New York reformers, and a friend of Lillian Wald, and had been influenced by John Dewey and experiments in progressive public education. She focused on a whole-child approach to learning and worked to adapt the schools to fit the situation of the students when they entered the classroom. She also advocated for more extension of the school into homes with the introduction of visiting teachers in order to examine more fully the social conditions of students. She enacted changes in the curriculum to include vocational education and cooking classes. Furthermore, she made changes to get special education and care for handicapped children within the schools.¹⁰⁸

Reformers were trying to create not just a metaphorical space for the school as the center

¹⁰⁸ Selma C. Berrol, "Superintendent Julia Richman: A Social Progressive in the Public Schools," *The Elementary School Journal* 72, no. 8 (May 1972): 402–11; Selma Cantor Berrol, *Julia Richman: A Notable Woman* (Philadelphia: Balch Institute Press, 1993); Lawrence A. Cremin, *The Transformation of the School; Progressivism in American Education, 1876-1957* (New York: Knopf, 1961).

of people's lives, but also a physical space, by opening up schools as activity centers for the communities, much in the way of the church basement now. As both Sol Cohen and Selma Cantor Berrol demonstrated, schools were increasingly seen as not places just for the children to learn during daytime hours during the academic year, but "for the use of the whole neighborhood," a place for community members to gather during the evenings and vacations.¹⁰⁹ Instead of looking for ways to limit access to schools, reformers were continuously looking for new ways to use the same building. For example, in 1901, one author suggested "The Coffee House Plan" as a way to get people out of the saloons and into a new form of socialization.¹¹⁰ Schools could be used for recreation spaces, kindergartens, and evening classes, advocates argued. Reformers not only believed that these programs should be brought to a greater and wider public, they believed that the responsibility to provide them fell to the city.

The New York Public School system began creating vacation schools and playgrounds under its own authority in 1898. The New York Association for Improving the Condition of the Poor had offered vacation schools held in public school buildings for the previous four years. In

¹⁰⁹ Sol Cohen, *Progressives and Urban School Reform: The Public Education Association, of New York City, 1895-1954* (New York: Bureau of Publications, Teachers College, Columbia University, 1964); Selma Cantor Berrol, *Immigrants at School: New York City, 1898-1914*, Bilingual-Bicultural Education in the United States (Ayer Co Pub, 1978); Kevin Mattson, *Creating a Democratic Public: The Struggle for Urban Participatory Democracy During the Progressive Era* (University Park, Pa: Pennsylvania State University Press, 1998). Kevin Mattson has written about the Social Center Movement that originated in Rochester. This movement, started in 1907, was organized to congregate in public school buildings in order for community members to discuss and educate themselves on social issues, some local and very concrete, such as where to put the tracks of local streetcars and the creation of a local public library, and others that reached concerns on the national level, such as immigration and citizenship. All of these discussions were organized by the people themselves, and not by the Board of Education, although it did provide the funds. Reformers came to visit Rochester to see the social centers in action firsthand, and spread the word to help the Social Center movement take hold across the nation, at least for a very brief moment. The social center movement, Mattson argued, engaged community members to educate themselves on social issues.

¹¹⁰ Arthur Lawrence Sweetser, "The Coffee House Plan," *Gunton's Magazine*, September 1901, 239.

July of 1898, the city opened ten vacation schools and twenty-four vacation playgrounds for six to eight weeks during the summer months while regular classes were not in session. In the vacation schools, activities were divided between the smaller and older children, with kindergarten classes for the littlest, while the older children participated in activities as diverse as nature study, drawing, painting, and music alongside learning more practical skills like cooking, sewing, woodworking, carpentry and hat-making, among others.¹¹¹ Rooftop and open-air playgrounds and other outdoor activities were added as well, including day trips for swimming. The following year, evening recreation centers were opened up in some school buildings from 7 to 10 p.m. throughout the year, allowing those children who worked during the day to have access to recreational activities and clubs as well as providing a place for adult groups, like Mothers' Clubs, to meet. The space was divided to have suitable areas for rougher play such as "gymnasium work, basketball, and other games of that character" and for quiet leisure like games and reading. Finally, both evening high schools and kindergarten classes were established throughout New York, expanding the number of children who could benefit from free education. Evening high schools would continue to provide education for those students who otherwise had to work.¹¹²

A. Emerson Palmer, early historian of New York City schools, called this project "the enlarged use of school buildings."¹¹³ So here we have both the expansion of the services provided, and an enlargement of the uses of the buildings themselves. Schools were becoming a bigger part of the lives of children and their families. More of the services that once only

¹¹¹ Nature study was at its height during the Progressive Era. Kevin C. Armitage, *The Nature Study Movement: The Forgotten Popularizer of America's Conservation Ethic* (Lawrence: University Press of Kansas, 2009).

¹¹² A. Emerson Palmer, *The New York Public School: Being a History of Free Education in the City of New York* (New York: MacMillan, 1905), 287–288.

¹¹³ *Ibid.*, 288.

settlement houses provided were then granted in public schools, so it seemed clear to many reformers that health care should also be provided to these children. The infant welfare clinics, dispensaries, and other programs for the reduction of infant mortality had provided a level of access to children and families that was not available previously, but the school was increasingly seen as the primary agency in children's lives.

More importantly, the school was seen as a site in which a sense of democracy was both instilled and enacted. Lillian Wald called the public school "the stronghold of democracy." This belief, she wrote "lies deep in the hearts of those social enthusiasts who would keep the school free from the demoralization of cant and impure politics, and restore it to the people, a shrine for education, a center for public uses."¹¹⁴ Although Wald did not necessarily articulate her reasons why school was so important in the lives of immigrant children, she did defend their right to attend and to stay in classrooms. While many reformers would uphold the school as a place for children to become Americanized, Wald stayed true to her rhetoric by instead insisting that for many immigrants, education was closely tied to their own values and aspirations for their children.¹¹⁵ In *The House on Henry Street*, Wald's section on "Children and Education"

¹¹⁴ Wald, *The House on Henry Street*, 133.

¹¹⁵ Katrina Irving, *Immigrant Mothers: Narratives of Race and Maternity, 1890-1925* (Urbana: University of Illinois Press, 2000). Katrina Irving argued that Wald "employed a rhetoric of deficient maternity that simultaneously underscored the conflict between the woman's desire to fulfill the ideal of sentimental motherhood and her inability to do so." Irving said that reformers were using nineteenth-century sentimentalist ideology as the standard of normative maternity that they sought to instill in immigrant women. Irving argued that reformers focused on the mother and the home as a central site of Americanization because the mother was understood as the primary transmitter of educational, cultural, and moral values (as well as racial qualities) to the next generation. When she failed to live up to the ideal because her economic situation depended on working, reformers still described them as aspiring to this standard and helpless to achieve it. Irving's book, however, does not take into consideration that these reformers were also speaking to a white middle-class audience and were attempting to capture the immigrant mothers as sympathetic cases to those middle-class women who were financially able to contribute to their cause.

emphasized that the Russian Jewish immigrant's most ardent wish was for their children to have access to education, which was available to them in the United States while it had not been in their native country. She detailed this with many of the hardships that both parents and children endured in order to obtain schooling.

Robert Woods, head resident of the South End House in Boston and promoter of the social settlement house movement, argued that the public schools had a "difficult missionary task to perform" in his book *The City Wilderness: A Study of the South End*, first published in Boston in 1898.¹¹⁶ Woods was especially interested in "the streets" of Boston's slums, and the environmental influence they had on children. Woods emphasized the importance of kindergartens and manual training as a means to keep immigrant children away from the pull of the streets and the concomitant dangers and vices. He, too, saw the public school as the central agency in the lives of children, and more than any other reformers discussed here, saw the school as the instiller of probity and punctuality. Woods called the school an "agency of righteousness"; he said that it should not only impart "book-learning," but also "bring light and life and social healing." Teachers could give immigrant children new values, and the lessons of history could provide other models for living. Furthermore, the control and discipline both enforced in the structure and the individual's ability to succeed within it could teach immigrants to become more orderly themselves. In this way, it brought students "within the realm of government."

The multiple meanings of the word "government" that Woods evoked here should not be overlooked. He did mean that schools could bring children under management, to make them

¹¹⁶ Robert Archey Woods, *The City Wilderness; a Settlement Study by Residents and Associates of the South End House* (Boston: Houghton, Mifflin and Company, 1899); Robert Archey Woods and South End House (Boston, Mass.), *Americans in Process; a Settlement Study* (Boston: Houghton, Mifflin, 1903); Robert Archey Woods and Albert Joseph Kennedy, *Handbook of Settlements* (Charities Publication Committee, 1911); Robert Archey Woods, *The Settlement Horizon; a National Estimate* (New York: Russell Sage Foundation, 1922).

more easily governed by others. But the school also gave pupils early education in the practice of democracy and active government. Woods said that kindergartens molded children into “social beings”; in the kindergarten, he argued, children learned the basics of self-control and the submission of individualistic impulses to the good of the whole. Kindergartens were “a child’s democracy, a cooperative state in miniature.”¹¹⁷ So for Woods, the school provided both the moral integrity and discipline required of citizens, while also giving the opportunity to test out democracy in a sort of proto-government.

Woods also went on to discuss the very reach of the government and how it made these actions possible. “[The school] is the one institution which touches every family. The law requiring the attendance of all children between eight and fourteen years of age, which is faithfully enforced, gives the schools a full harvest of influence with the entire child life of the district. With this reach of power, the schools make the essential beginnings both of individual and collective development.”¹¹⁸ Since the school did have such a powerful reach, Woods also hoped for more interaction between the home and the school, but decided that in practice this kind of work would be too burdensome for teachers. Once again, reformers saw the school as the primary institution in the lives of immigrant children, and thus the best means to bring about change in neighborhoods and communities. Even though the motivations of reformers may have alternated between paternalistic and empowering, the school was the site in which children could become better citizens.

If public education was seen as crucial to democracy, reformers saw healthcare as the necessary

¹¹⁷ Woods, *The City Wilderness; a Settlement Study by Residents and Associates of the South End House*, 236.

¹¹⁸ *Ibid.*, 231.

complement. Lina Rogers took for granted that the school had a crucial role in the lives of children; she thought it was the one place the child should learn how to deal with all that he or she was to encounter, and wrote that it was “the training ground of every child for the battle of life.”¹¹⁹ Rogers saw healthcare as the necessary addition to the growing responsibilities and functions of the school. It should be “preparation and training that will fit him physically, mentally, and morally for his place in the world, so that each one is given the opportunity to secure health, happiness, and success.”¹²⁰ These treatments were seen as a way to rescue school time stolen from immigrant children; Rogers thought it especially important “that not a day should be lost” since they often had few educational opportunities to begin with, “as the great majority [were] taken from school at fourteen years of age and sent to work.”¹²¹

By 1906, the Assistant Chief Medical Inspector, Dr. John J. Cronin, would offer up the system of medical care in the schools as the panacea for all social ills, arguing that it would eliminate poverty and class disparity, if not immediately, then in the next generation of children. This uplifted generation touched by medical inspection would grow up and demand better circumstances for their own children. “Then as far as bodily cleanliness and diseases are concerned, there will be no lower classes. Education will have made us equal and the purpose of the medical inspection of schools as established by the Department of Health in New York City, will have been realized.”¹²²

If the schools were, in many ways, taking on projects that were piloted in the settlement houses,

¹¹⁹ Rogers Struthers, *The School Nurse*, 2.

¹²⁰ Ibid.

¹²¹ Rogers, “School Nursing in New York City”; Rogers, R.N., “What the Public School Nurse Is Doing”; Rogers, “The Nurse in the Public School,” 766–767.

¹²² John J. Cronin, M.D., “School Children and Their Medical Supervision,” *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance* 16, no. 1 (1906).

the school nurse was also an extension of the values of the Henry Street Visiting Nurse Service. And we can see the same kind of dignity and care that was espoused by Lillian Wald in the actions of Lina Rogers as a nurse and in her treatment of her young patients. The school nurse reflected the conviction of progressive reformers to transform the state's relationship to the family, to enlarge the responsibilities of schools to include a whole-child and extended-school approach, and to insist that the government take responsibility not just for the education of a child, but also for his or her health. Although visiting nurses performed many of the same duties in the homes of families as school nurses, the school nurse indicated a change in responsibility: while settlement houses were funded by benefactors, nurses and doctors in the schools were paid for by the state. Because of the efforts of progressive reformers like Lillian Wald and Lina Rogers, New York City became the first city in the world to take nurses out of private associations and place them under municipal control.

Treating children for their illnesses, rather than merely excluding them, was a powerful means of extending the rights of citizenship to children and immigrants in the midst of a wave of nativism that pathologized foreign bodies. By healing, by keeping the immigrant body free from disease, nurses made room for the possibility of inclusion. Medical inspectors continued to deal with those children who had contagious diseases that needed to be reported to the Board of Health: scarlet fever, diphtheria, and cholera. Nurses took on the responsibility of those so-called immigrant diseases that were not life-threatening, but could be considered “loathsome”—head lice, favus, ringworm, and trachoma—and treated them so that children could be returned to the classroom.

The current narrative of the Progressive Era is that white middle-class reformers were living in a time of anxiety over rapid change, and looked to impose their values on disorderly

immigrants as a method of social control. But we can see in the practice of school nursing both a commitment to the rights and dignity of immigrants, and the desire to implement a broader culture of care and responsibility. Health education and treatment represented a progressive commitment to the assimilation of the immigrant in the democracy, in this case, through medical care. They advocated inclusion, not exclusion, of the immigrant, both at the borders of the United States and within the political and social body. Lina Rogers and Lillian Wald believed that health care was a necessary right, since it was the prerequisite for children to have the benefit of their other fundamental right: public education.



An interval: Lina Rogers, before and after Henry Street

Lina Rogers, date unknown¹

Although Lillian Wald got most of the credit for inventing the concept of school nursing, she hired a very competent and qualified person to implement it, which helped it to succeed. Lina Lavanche Rogers already had experience as a nurse in several hospitals, and had specialized training in the care of children. After her time working at Henry Street and for the City of New York, she would go on to found other school nursing programs in the United States and Canada, and establish herself as an important member of the nursing profession. Rogers also remained devoted to her friends and colleagues at Henry Street, and would return again later in life, continually called back to the friendship and sense of purpose that the settlement provided to many of its first residents.

Rogers was born in 1870 in Albion Township of Ontario, Canada.² Little is

¹ *Headshot of Lina Rogers*, Photograph, n.d., Image 0977-045-004, Hospital Archives, The Hospital for Sick Children, Toronto.

² No historians have tried to dig too deeply into the personal life of Lina Rogers. Rogers did not write a personal account the way Lillian Wald did, nor were her personal papers kept. She was not even a named person in Lillian Wald's papers, and instead I found her correspondence in an alphabetical listing of "staff correspondence." I have attempted to tease out a bit more of the life of Lina Rogers through other sources and try to provide depth to her character despite limited information. P. Pollitt, "Lina Rogers Struthers: The First School Nurse," *The Journal of School Nursing: The Official Publication of the National Association of School Nurses* 10, no. 1 (February 1994): 34–36; Casey Schumacher, "Lina Rogers: A Pioneer in School Nursing," *The Journal of School*

known about her early life, and for us, her story aptly begins when she started her nursing training at the Hospital for Sick Children in Toronto in 1892. The Hospital had its own innovative history focusing on children's health, and no doubt this made Rogers an ideal candidate for the school nursing position that would arrive a decade later.

Elizabeth McMaster founded the Toronto Hospital for Sick Children in March of 1875, and it was the first institution in North America devoted completely to the needs of children.³ Sick Children's operated as a religious charity; it treated Toronto's poor youth for free, but also exposed the hospital inmates to a good helping of prayers and religious education. It took a while to gain the trust of local parents, many of whom felt their children were better off under the care of mothers at home than sent to hospitals, which still had the reputation of being frightening places for the destitute and dying. But eventually the hospital gained patients of all kinds, and treated some of Toronto's most seriously ill and injured children: chronic and emergency cases, surgical and medical. They treated burns, from scalding water to swallowed lye, and many tubercular cases, both of the lungs and the bone. Many of the children could be strengthened with fresh air, sunshine and proper nutrition, as well as daily care and cleaning of their wounds. But the surgeons at the hospital were very advanced in their field. They took on complicated

Nursing: The Official Publication of the National Association of School Nurses 18, no. 5 (October 2002): 247–49; M. Kaufman, ed., "Lina Rogers Struthers," in *Dictionary of American Nursing Biography* (Greenwood Pub Group, 1988), 354–57.

³ Max Braithwaite, *Sick Kids: The Story of the Hospital for Sick Children in Toronto* (Toronto: McClelland and Stewart, 1974). Although it was initially an institution founded and run by philanthropic women, Elizabeth McMaster eventually lost control of the hospital, as finances and fundraising necessitated a Board— all male— that pushed her out of major decisions. Elizabeth McMaster was not a trained nurse, and she decided that in order to have more power at the hospital, she needed to get a nursing degree, and left for Chicago in 1889. She returned briefly as Superintendent of the Hospital. In 1891, when John Ross Robertson was elected chair of the board of the new hospital, the Ladies Committee lost all ownership. McMaster left for good in 1892.

surgeries that few doctors were capable of handling at the time, such as cleft palates and clubfoot, as well as tuberculosis of the bones.



Lina Rogers and her graduating class at the Hospital for Sick Children, Toronto. Rogers is fourth from the right in the back row. The woman in the center is their instructor, Miss Kesiah Underhill.⁴

The preparation that Rogers received at Sick Children's was among the best of its time. During Rogers's stint, the two-year training was led by Kesiah Underhill; in 1896, it would be increased to three years under the leadership of Louise Brent. Like many of the better training schools, it included a course of lectures and bedside clinics; the first nursing programs had used only hands-on apprenticeships that had turned out ill-prepared and over-worked nurses. The graduation ceremonies held on January 31, 1894 for Lina Rogers's class emphasized this course of classroom instruction as a crucial part of the high-quality education they received.⁵

⁴ *Staff Photo from Toronto Hospital for Sick Kids*, Photograph, 1893, Image 0973-067-001a, Hospital Archives, The Hospital for Sick Children, Toronto.

⁵ “It Was Gracefully Done. The Mayor Presents Medals Honoring the Trained Nurses-the Hospital for Sick Children the Scene of an Interesting Ceremony,” *Annual Report of the Hospital for Sick Kids*, 1894, The Hospital for Sick Children Hospital Library & Archives.

After her training at The Hospital for Sick Children, Rogers moved to Montreal for a post-doctoral program at Royal Victoria Hospital. She was engaged to work there on February 27th, 1894, with references from the Superintendent of Nurses at Children's.⁶ Eventually she was made Head Nurse and Night Superintendent.⁷ It is unclear when Rogers left Montreal, but probably around 1899. Rogers then went to The Grady School of Nursing in Atlanta as the Superintendent of their training program.⁸ On May 16, 1900, Grady graduated its first trained nurses, and a photo showed Miss Lina Rogers surrounded by the class of six students.⁹ Grady had opened up a Children's Ward in 1897 with the help of philanthropist Nellie Peters Black. Presumably Grady's nurses-in-training also worked with these children in their isolated ward, and Rogers gained valuable experience training nurses to work with children's ailments.

In 1902, Rogers resigned from Grady. Although we can't be sure why Rogers left, it was just in time. By 1905, nurses revolted against the next Superintendent, Miss Margaret A. McGroarty, a northerner trained at Bellevue Hospital, for berating white nurses in front of black patients. Following the walkout of 12 nurses, a third of the force, and the Superintendent's resignation, the Board made the concession to the mayor that all future superintendents of the school would have to be southerners—those who

⁶ "R.V.H. Register of Nurses Employed C. 1893-1898," n.d., R.G. 95 Royal Victoria Hospital Container 402, McGill University Archives.

⁷ M. Kaufman, *Dictionary of American Nursing Biography* (Greenwood Pub Group, 1988).

⁸ The Atlanta History Center holds the Grady Memorial Hospital Collection, 1892-1980, but none of the material described seems to match up to the time that Rogers would have been employed at the hospital. It also holds the Grady Memorial Hospital Photograph Collection. The University of Georgia holds the School of Nursing Records of Grady Memorial Hospital, but the records begin in 1908.

⁹ *Lina Rogers and Her Cohort at Grady Memorial Hospital in Atlanta*, c 1900, Image 0986-006-001, Hospital Archives, The Hospital for Sick Children, Toronto.

understood the race expectations of the South.¹⁰



Lina Rogers and her first class of students at Grady in Atlanta, 1900.

I have been unable to locate the initial correspondence that might have shown how Lina Rogers ended up at Henry Street, but she was there for at least six years, and established professional relationships that would last a lifetime. She became a part of Lillian Wald's "old girl network." Membership to this circle was sometimes by introduction, but according to historian Doris G. Daniels, "the real requirements for membership were talent, personality, adaptability, and spirit ..." and for Wald, "the 'old girls,' who tried to pioneer a profession for nurses, would always receive special love and loyalty."¹¹ Much like her colleague Lavinia Dock, Rogers worked to professionalize nursing, demanding higher educational standards and state licensing to practice in the field. She also became deeply committed to the nursing community by becoming an active member of her alumnae organization and a part of nursing associations. In 1906, she became the first lifetime member of the Alumnae Association of the Hospital for Sick

¹⁰ Martin Moran, *Atlanta's Living Legacy: A History of Grady Memorial Hospital and Its People* (Atlanta: Kimbark Publishing, 2012), 51.

¹¹ Doris Groshen Daniels, *Always a Sister: The Feminism of Lillian D. Wald* (New York: The Feminist Press at the City University of New York, 1989), 24–25.

Children Training School for Nurses. In 1907, *The Canadian Nurse* announced that both Dock and Rogers planned to attend the International Council of Nurses in France in June. Lina Rogers was on the Board of Directors of the Graduate Nurses' Association of Ontario from 1909 to 1910. Rogers would also serve on the editorial board of *The Canadian Nurse and Hospital Review*, and would attend and speak at conferences in both the United States and Canada.

When Rogers left New York in 1908, it appears the most favorable offer she received was the one from Pueblo, Colorado. According to author and former superintendent of the district James H. Risley, the addition of a school nurse had been proposed by the Board of Lady Advisors as part of a larger program to prevent “wreckage”; that is, “the youth who for various reasons drop out of school or fail to profit by the school program.”¹² The changes that they wished to enact were similar to the progressive changes in the New York City school system, including the use of schools as social centers, the expansion of vocational education, and the increased concern with the physical health of children. Starting in January 1909, Lina Rogers was given “carte blanche” to create and lead the school nursing program for the Board of Education of Pueblo.¹³ She was fully in charge—there were not even any doctors appointed yet. During her time there, it appears that she was the only nurse in charge of 4000 pupils in twelve schools.¹⁴ Rogers resigned from Pueblo in February of 1910 “after urgent calls from the

¹² James H. Risley, *How It Grew: A History of Pueblo Public Schools* (Denver: University of Denver Press, 1953).

¹³ Canadian National Association of Trained Nurses, “Personal,” *The Canadian Nurse: A Monthly Journal for the Nursing Profession in Canada* IV (1908): 626.

¹⁴ James H. Risley, *How It Grew: A History of Pueblo Public Schools* (Denver: University of Denver Press, 1953).

Board of Education in Toronto.”¹⁵ It is unclear how and if the Pueblo program persisted after her departure, because Risley wrote that the first school nurse in District One of Pueblo was not hired until 1915.¹⁶

On April 21, 1910, Rogers was hired as the Supervising School Nurse of Toronto, over the objections of Toronto’s chief medical officer, who said that school medical inspection was “a pure fad, instituted principally by women” and insinuated that inspector positions were plum jobs that administrators gave away to their friends.¹⁷ But with the prompting of prominent newspaperman and philanthropist John Ross Robertson, Toronto hired its first medical inspector, and soon after, Lina Rogers.

The *Canadian Journal of Nursing* in June reported her appointment with great congratulations to the Board of Education for choosing such a qualified candidate. On May 5, Miss Rogers was given two nurses to serve on her staff: Miss Alice M. Robertson, and Miss Ella J. Jamieson.¹⁸ Both were graduates of the Hospital for Sick Children, 1905 and 1896, respectively. In February of 1911, the staff had increased to seventeen nurses, eight medical inspectors, and a dental inspector. The chief medical inspector, Dr. William E. Struthers, was hired in 1911.

¹⁵ Lavinia L. Dock and Mary Adelaide Nutting, *A History of Nursing: The Evolution of Nursing Systems from the Earliest Times to the Foundations of the First English and American Training Schools for Nurses* (Putnam, 1912), 157–158.

¹⁶ James H. Risley, *How It Grew: A History of Pueblo Public Schools*, 131.

¹⁷ Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto ; Buffalo: University of Toronto Press, 1976), 47.

¹⁸ Lina L. Rogers, “School Nursing in Toronto, Canada: First Paper,” *The American Journal of Nursing* 12, no. 1 (October 1911): 19–22; The Canadian National Association of Trained Nurses, “School Nurse in Toronto,” *The Canadian Nurse* VI, no. 6 (June 1910).



Lina Rogers leading a Little Mothers' Club in Toronto¹⁹

On July 9, 1913, Lina Rogers and Dr. Struthers were married. The event was announced in the *American Journal of Nursing*.²⁰ Once Rogers got married, she retired from her school nursing position in Toronto as she was expected to do. She and her husband graciously hosted a social gathering at their home at 558 Bathurst Street to pass the torch to the new Superintendent of Nurses, Miss E.M. Paul.²¹ Despite her married retirement, Lina Rogers Struthers continued writing and consulting, and was the Chairman of the School Nursing Committee of the Montreal Organization of Public Health Nursing from 1913-1916. In 1917, her nursing manual was published.

Dr. Struthers shared or absorbed Lina's strong belief that school medical inspection should be under the Board of Education, and he was willing to sacrifice his job in order to stand behind it. In 1916, to save money after a financial crisis from the war, the city's medical officer wanted to eliminate the duplication of work among the different nursing staff, especially home visiting. The solution was to bring the two departments

¹⁹ "Little Mothers' Class" - Board of Education - High Park, Photograph, n.d., Fonds 200, Series 372, Subseries 11, Item 67, City of Toronto Archives.

²⁰ "Nursing News and Announcements," *The American Journal of Nursing* 13, no. 11 (August 1913): 868-97.

²¹ "The School Nurse," *The Canadian Nurse and Hospital Review*, November 1913, 733.

under the Board of Health, despite strong resistance from the Board of Education. The city put it to a vote, and the cost savings won out. Rather than submit to this change by joining the staff at the Board of Health, W.E. Struthers chose to join the Canadian Army Medical Corps.²² In March of 1916, Dr. Struthers enlisted, and from 1917-1918 he served overseas.²³ This provided the opportunity for Mrs. Struthers to return to Henry Street and resume active duty as a nurse. On December 7, 1916, Lillian Wald wrote to her to request that she “spend the winter with [them] on a professional basis, perhaps doing some supervisory work for the infantile paralysis children.” Wald wasn’t sure what Lina’s situation was, but maybe she would like to “come and get to work” and “come back to your own for a time.” It was signed “Much love to you.”²⁴ Lina took this request very seriously, and in her reply, she stated that while Dr. Struthers was still stateside, she couldn’t leave, but she knew that her husband would be “ordered to go overseas shortly” and “It would do me good to be back for a while—I am getting over my nerves and will feel the pressure when Will leaves.”²⁵

When Rogers and Struthers were married, Dr. Struthers had two young children, Gordon (1904) and Margaret (1906), from a previous marriage to Jeannie Bennett Brown that ended with her death in 1908. Gordon had died at the age of twelve, contracting lockjaw after cutting his finger collecting eggs at a relative’s farm in Bayfield, Ontario, just months before Wald’s letter. So Lina would need to take ten-year- old Margaret with

²² Baker, S. Josephine, “The Medical Inspection and Examination of School Children in New York City,” *Annals of Gynecology and Pediatrics* 19, no. 8 (August 1906): 441–451.

²³ Cynthia Comacchio, “William Eugene Struthers,” *Dictionary of Canadian Biography Online*, n.d.

²⁴ Lillian D. Wald, “Letter to Lina Rogers Struthers,” n.d., Reel 85/ Box 70 Folder 1.14, Lillian D. Wald Papers, Rare Book and Manuscript Library, Columbia University.

²⁵ Ibid.

her to New York, and she knew that 265 Henry Street couldn't or wouldn't house a family. Wald suggested that Margaret stay with her living grandmother, so that Lina could reside at the main house. But that clearly wasn't an option for Lina, because she instead chose to go to one of the more remote settlements that did allow families. Although I am sure this was quite a sacrifice for Lina, who wanted to take up residence at the old house among her old friends, she had new priorities.

The Richmond County Medical Society wanted the Henry Street Visiting Nurse Service to establish a branch in Staten Island, and that looked like a viable option. In her letter of May 25th, 1917, Lina pronounced Wald's plan of starting up a Settlement in Staten Island to be "splendid." "It should have been done years ago. When I remember the tiny tots, five years of age, who went to schools after having had cognac in their tea, I shudder yet. Think of that and nothing else for breakfast. They are now very likely mothers or prospective mothers." Struthers expressed her desire to go "if things could be arranged satisfactorily." Lina was a little anxious about how long it had been since she had been actively practicing nursing, rather than just writing about it. But she was confident that her experience would carry her through in the end. "You will imagine that I am at a disadvantage, not having been in active work for so long," she wrote to Wald, "but my brain ought to be of some use still."²⁶ The details are unclear, but in the Settlement Report of 1918, it was relayed that the Staten Island branch had opened "under the supervision of Mrs. Struthers, who as Miss Lina Rogers did conspicuous work in establishing school nursing in New York City."²⁷

²⁶ Ibid. This letter also included a photo of Lina and Margaret reading a book together.

²⁷ Henry Street Settlement, *Report of the Henry Street Settlement 1893-1918* (Henry Street Settlement, 1918), 21.

Lina's talent and experience, as well as her friendships with the other settlement nurses, gave her a lot of leverage. Wald's loyalty to her 'old girls' was well demonstrated in the case of the Staten Island Branch. One can understand why the settlements might not have wanted to deal with married women with families, when Lina was so persnickety about living arrangements. And, after 18 months of correspondence, Lina still couldn't work out a definite decision to come. Henry Street Settlement probably had a line of young nurses ready to take the position that Wald was holding for Lina. But the wooing continued from the Henry Street side, and the promises and hold-offs came from Bathurst Street in Toronto, until eventually Lina did return to New York to supervise the Staten Island Branch. It wasn't just a negotiation; there was clearly much love on both sides, and I have no doubt that the encouragement for Lina to return to Henry Street was a group of friends who thought that one of their own was once again in need of the love and support of this circle of women after the death of a child and the departure of a husband for war.

Mrs. Struthers most likely returned to Toronto after the war to resume living with her husband. In 1931, Wald wrote to inform her of the death of one of the members of the old family, Rebecca Schatz, and to tell her of Jane Addams's visit to Toronto to speak on behalf of the Women's International League. Since we can't revive the conversations of the Henry Street table, I am grateful for the distance that required the nurses to put their friendship in words. We can sense the sheer joy of that companionship that emerges when its participants have left its embrace, having to put their lives into letters because distance, somehow, made their lives permanent to us even while their proximity to each other is lost. The Henry Street table remained an intimate, sheltered place, a home even

while they charged forward into public space. The tone of Lina's letters to Wald reminds us of their love and admiration for each other, and their fondness for the early years at Henry Street, even with such a passing of time. Lina prodded Lillian to visit Toronto while Jane Addams was in town, jesting with assurance that Lillian would accept, even as Lina knew that Wald's failing health wouldn't allow it. Lina suggested that Misses Wald and Addams could hole up quietly in her little home, and they would not have to bother with meetings. The joke, of course, was that neither Wald nor Addams could ever take a rest from work, even when it was needed.²⁸

Lina was grateful to be kept in the loop, but could not bear to go to Rebecca's service. It would be too much of a "heart stir." She would rather have the chance to just sit and have a quiet conversation with her old friend. "I'll go some time when I can just visit a little with you, if you are ever quiet long enough for visitors." Perhaps she did make the trip. But Rogers did not spend too much time thinking about her old life. She had been interviewed by someone asking lots of questions about Wald's early years, but she did not seem interested in retelling those tales. In her later years, she devoted most of her time to "church work." She wrote, "I am really past history now."²⁹ She died on June 26, 1946.

²⁸ Lina Rogers Struthers, "Letter to Lillian Wald," April 30, 1931, Reel 59, Lillian D. Wald Papers. Rare Book and Manuscript Library. Columbia University.

²⁹ Ibid.

Chapter Three

“The bond of friendship”: Bringing home the message of health



A home visit¹

Lina Rogers returned the kerosene and sweet oil, the tincture of green soap, the bandages; it wasn't much of a spot, her little work station. The principal had found her a corner to set up her clinic, but it had to be rebuilt each day. She emptied out the basins, and checked levels on the bottles before placing them on their assigned shelf. She straightened then shuttered her supply closet, locked it, pocketed the key.

She filled out her paperwork, totaling the number of students she had seen for impetigo, for favus, for pediculosis. She had an index card for each child with their tallies: ages, dates of treatments, number of days missing, the digits that coded the reasons for treatments and absences. She took out the cards she needed, mapped her afternoon by the addresses, and left the school promptly at 3 pm.

¹ Baker, S. Josephine, “The Medical Inspection and Examination of School Children in New York City,” *Annals of Gynecology and Pediatrics* 19, no. 8 (August 1906): 441–51.

The address on her first index card: she knew the street well; she was among the newer nurses at the settlement, but with the heavy schedule of visiting, it didn't take long for her to recognize the tenement building. The children in the street recognized her too; if not Miss Rogers, they at least knew the Henry Street dress, hat, bag. "Ha-llo!" the boys shouted, running past her, unconsciously wiping their hands on their trousers to clean off the dirt from their play, then reaching up to smear their faces. The girls on the stoop paused their circled chatter to lift their heads to eye her timidly, wondering whom she was here to see. "Hello, children," she said, sweeping her skirts past, careful not to bump any heads with her bag.

As she opened up the door, her eyes had to adjust to the dark inside. She waited there a moment before braving the stairs. When she found the door, she knocked confidently but quietly. She could hear some muttering from behind, but it was muffled by distance and foreignness. The words and steps approached, and in that beat, she took a breath to brace herself for whatever might come next. Instead of armoring herself against the tirade that might befall her with stiffness and authority, she used her gentlest offensive, softening her shoulders and warming her eyes. Although a Henry Street nurse was used to knocking on doors, a school nurse came uninvited.

"Hello," she said with her biggest smile. "My name is Miss Rogers. I am the nurse from your daughter's school. I would just like to talk to you for a few minutes if now is a good time?" It wasn't a good time. The mother had been peeling potatoes, dropping the parings onto newspaper on the table, leaving her fingers slimy with wet dirt. But wiping her hands she led her to the one cleared chair, and offered her a seat while she straightened up the kitchen. Miss Rogers tried to keep her eyes from wandering too obviously, but it was hard to resist a look around when the mother turned her back, and there were plenty of other eyes to catch her glances. A toddler wandered into an older child's lap.

The nurse asked how the children were doing in school, and the mother shrugged unsurely, wary of the expectations. "She must be doing well. She is very smart. But she must be terribly bothered by the itching." The mother looked up from her clanking of dishes, waiting for her to go on, and

the nurse used this as her entry. "I treated Anna for pediculosis today. I wanted to show you how to treat it too, since it is very contagious and the other children might have it."

Miss Rogers had spent her day with her hands in hair, thumbing for nits. The girl sat on a stool in front of her as she dragged her nails across the shafts of hair to check on the progress of treatment. She had already soaked her hair today, so she called over one of the siblings. "May I check his hair too?" she asked the mother. The mother was nervous, but nodded her assent. The younger child took his place on the chair as the nurse talked her way through the examination. It was no surprise that all of the children, who most likely shared a bed and towels, would share the same pests. She showed the mother the lice, the nits. The mother fumed a little resentfully, but she looked quickly and nodded. "Oh yes, of course, such nuisances. Always bothering us!" The nurse treated the younger child, and the kerosene fumes forced tears to stream from his burning eyes. The older sister watched too, sure she would have to repeat the treatment.

When it was done, the nurse explained that everyone in the house must be treated and checked, otherwise the pests would return. She handed out pamphlets with instructions. She made some statements that she knew to be absurd owing to the impossibility of compliance: the tenement flat was too small to expect the children to have separate beds, the parents too poor to provide clean towels every day for each child. But she said it all the same. Then she had to be firm: Anna wouldn't be able to return to school unless the treatment was maintained. It would only succeed if the whole family participated. Rogers could sense when parents would do their best. This mother seemed intelligent and willing. "Of course, of course. Thank you."²

² The description of the home visit is fictionalized based on the descriptions of Lina Rogers: Lina L. Rogers, R.N., "What the Public School Nurse Is Doing," *The Visiting Nurse Quarterly* 2 (1910): 14–18; Lina L. Rogers, "School Nursing in New York City," *The American Journal of Nursing* 3, no. 6 (March 1903): 448–50; Lina L. Rogers, "A Year's Work for the Children in New York Schools," *The American Journal of Nursing* 4, no. 3 (December 1903): 181–84; Lina Rogers Struthers, *The School Nurse; a Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease Among School Children* (New York and London: G.P. Putnam and Sons, 1917), 4, 8, 47–56, 72. Adele Marie Shaw offered an objective perspective that corroborated Rogers' accounts: Adele Marie Shaw, "The True Character of New York Public Schools," *The World's Work*, December 1903.

School nurses succeeded in keeping more children in school by caring for their minor illnesses, but the “policy of inclusion” did not change the fact that children still got sick, nor did it change the gruesome conditions of the slums that contributed to the frequency of these illnesses. Thus nurses considered their jobs in the schools to be a minor part of their daily work, and in fact, their hours in the schools were far fewer than those spent performing the role of a traditional visiting nurse: caring for families in their homes. Remember that Lina Rogers had first been a visiting nurse at the Henry Street Settlement, and she brought the philosophy and practice of visiting nursing into her work as a school nurse. Although her role expanded when she became active in the schools and gained much more institutional power to make changes in the lives of her students, her basic mission was that of a Henry Street nurse. The “home visit” was the *sine qua non* of the visiting nurse’s profession and for the school nurse as well; or as Lina Rogers put it, “The nurse who fails in her home visiting may as well give up school nursing.”³

The home was equated with its embodiment: the mother. In a public effort that focused on a policy of prevention and education, reformers gave mothers a much bigger role in the “new public health.”⁴ While children were accessed easily through the settlement houses and through

³ Rogers Struthers, *The School Nurse*, 72.

⁴ Rima D. Apple, “Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries,” in *Mothers & Motherhood: Readings in American History* (Columbus: Ohio State University Press, 1997), 90–110; Rima D. Apple, *Mothers and Medicine: A Social History of Infant Feeding 1890-1950* (Madison: University of Wisconsin Press, 1987); Jacqueline H. Wolf, *Don’t Kill Your Baby: Public Health and the Decline of Breastfeeding in the Nineteenth and Twentieth Centuries*, Women and Health (Columbus: Ohio State University Press, 2001); Rima D Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, N.J: Rutgers University Press, 2006); Richard A. Meckel, “Save the Babies”: *American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*, The Henry E. Sigerist Series in the History of Medicine (Baltimore: Johns Hopkins University Press, 1990). “For an approach to scientific mothering among rural women, see: Lynne Curry, *Modern Mothers in the Heartland: Gender, Health, and Progress in Illinois, 1900-1930* (Columbus: Ohio State University Press, 1999). The new child psychology by G. Stanley Hall also elevated

schools, immigrant mothers were the demographic group that was most isolated from mainstream American life. They often did not leave the area within a few blocks of their homes, and they maintained very strong ties within the immigrant community. While children became American through schools, and men went to workplaces and were forced to ease up on certain traditions, immigrant women were often the most steadfast in maintaining the habits and mores of their homelands.⁵ The nurse's home visit was the best means to view the child's surroundings and the best way to instill the lessons of public health to those who were in the best situation to promote them, but otherwise the least likely to receive them.

The treatment of children was one new step in the medical involvement of schools, but the nurse's next important job was to educate mothers about the maintenance of children's health. After school hours, the nurse visited several homes to teach mothers how to care for their children properly, and in some cases, urged them to get additional medical treatment from a physician. The school nurse, then, was an important link between school and home, state and family. Her involvement with schoolchildren, through her service as their nurse, gave her an exclusive kind of access to both mothers and their children. The school was already an important point of intervention for immigrant children; nurses were also able to penetrate the homes of immigrant families in a way no other state agent could.

the mother as the expert on her own child. Alice Boardman Smuts and Robert W. Smuts, *Science in the Service of Children, 1893-1935* (New Haven: Yale University Press, 2006).

⁵ Elizabeth Ewen, *Immigrant Women in the Land of Dollars: Life and Culture on the Lower East Side, 1890-1925*, New Feminist Library (New York: Monthly Review Press, 1985); Selma Cantor Berrol, *Immigrants at School: New York City, 1898-1914*, Bilingual-Bicultural Education in the United States (Ayer Co Pub, 1978); Stephan F. Brumberg, *Going to America, Going to School: The Jewish Immigrant Public School Encounter in Turn-of-the-Century New York City* (New York: Praeger, 1986); Rose Cohen, *Out of the Shadow: A Russian Jewish Girlhood on the Lower East Side* (Cornell University Press, 1995). Rose Cohen recounted the first time she saw her father handle a coin on the Sabbath and how horrified and ashamed she was to have witnessed it. Her mother, however, was steadfast in her dress and behavior.

Rogers considered the work that she did at school as ameliorative, while what she did in homes as preventive. Rogers, of course, did not mean to diminish the effectiveness of her role at the school itself. But as a nurse, she continually focused on prevention and education as the way to keep healthy. She and her fellow nurses had already come to the conclusion that it was best to keep children well, rather than to try to cure them when they were sick. This part of the “caring” aspect of the nursing profession dealt with the maintenance of the normal, healthy child rather than merely the illness that plagued him; they also knew that the child existed within a community and that his surroundings affected his overall wellbeing. The nurses gave the mother instructions in personal care to help the child grow and develop: diet, amount of play and sleep, and the importance of sun and ventilation. Getting inside the homes of children gave the nurses an opening into teaching other skills and altering surroundings that may or may not be related to that particular illness.⁶

It required a special kind of tact on the part of the nurses to use a sick child to provide an opportunity for contact with parents and the means of access to the rest of the family.

“Incidentally, and in a polite and friendly way, the nurse can encourage cleanliness in the home, having the child bathed often, their ragged little clothes mended and washed, and their hair nicely combed.”⁷ This word “incidentally” is revealing because it is the exact word that Wald used to describe this aspect of home visiting when she outlined the role of the visiting nurses at the settlement, both underscoring the relationship between visiting nursing and school nursing,

⁶ Lina L. Rogers, “Nurses in the Public Schools of New York City,” *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance* 16 (April 7, 1906): 67.

⁷ Rogers, “School Nursing in New York City,” 449.

but also how the patient was to be treated in both cases.⁸ That is, to make the education a side purpose, rather than the main point, at least as far as the patient understands it. The nurse's visit should not look like the arrival of a pushy social worker or missionary, but rather as concern for a sick person who needed immediate aid. Rogers directed nurses to communicate with the utmost tact and diplomacy, and to win resistant parents over with their amicability and obvious care for the child. She knew that in the long run, taking an authoritative stance would not bring cooperation; instead, "her great weapons of attack will be unvarying courtesy, amiability, persistence, and child love."⁹

One of the most important aspects of home visiting was that it gave the nurse a chance to see the child in context, and perhaps to get to the root of a recurring illness. Often, the school nurse would be able to identify some situation in the homes or habits of the parents that would explain the child's own situation more fully. For example, Rogers discovered children who were being treated for head lice, but whose siblings were not, "the mothers not realizing that it was useless to keep the school child clean if all the others in the family were neglected." Or the home itself with "bad conditions of drains and sewers" or "filthy yards, where delicate children played." She might find other members of the family with contagious conditions like tuberculosis. "With such conditions in the homes it is obvious to all that the work done in the school must fail to have any real preventive character."¹⁰

School nurses were in the best position to evaluate the social conditions of a family, and they were often the first to respond to provide for children in need, even though it wasn't an

⁸ Lillian D. Wald, *The House on Henry Street* (New York: H. Holt and Company, 1915), 27.

⁹ Rogers Struthers, *The School Nurse*, 70–71.

¹⁰ Lina L. Rogers, "Some Phases of School Nursing," *The American Journal of Nursing* 8, no. 12 (September 1908): 970.

official part of their job description. Nurses were concerned with the family's ability to obtain shoes for children and provide adequate and nutritious food; they made sure that they had a salubrious home with breathable air and that it was free of family violence. If all of these conditions were not met, nurses mastered familiarity with all of the resources within the community, including relief agencies, free or low-cost dispensaries, and when necessary, the newly established family court system. But nurses also found their own means to aid children. In 1916, Dr. J.L. Blumenthal, a Bureau Chief in the Division of Child Hygiene, tabulated some of the social work that nurses carried out for the schools.¹¹ Dr. Blumenthal stated that many of the nurses had created year-round projects to help deal with the "social conditions." Nurses, for example, would gather clothes and shoes for children in need, keeping a store at the school for distribution. Other school nurses kept a fund of money donated by teachers to provide glasses and shoes. Sometimes the principal or a Parents Association would create emergency funds to provide for rent or other necessities, and nurses would determine which families could use them.

As a school nurse continued to take on this role, she became known as a "school social investigator" whom both teachers and principals relied upon to get additional information about students and their homes lives.¹² While others might have taken on these tasks, nurses were trusted and welcomed visitors; Blumenthal wrote in in a very telling observation that while families might be embarrassed about the state of their home for a teacher, most families did not feel shame about a nurse's visit, nor did gossip circulate among the neighbors. A nurse's visit, then, seemed an acceptable routine that did not draw attention to their economic plight. But the reason the nurse probably took on this task quite readily was that she felt it was a part of her job,

¹¹ J.L. Blumenthal, "Social Service Work of the School Nurses," *Monthly Bulletin of the Department of Health of the City of New York* VI, no. 1 (January 1916): 13–18.

¹² *Ibid.*, 14.

and she had the knowledge to perform this work and knew the social situations of families long before principals and teachers.

When nurses made home visits, they not only educated the mothers on the individual child, but any children they might find in the household. The health of the school child was in fact an entry point into discovering the health and social situation of an entire family, including younger siblings. Mothers could come to the milk stations in neighborhoods to get treatment for their babies, but there was no systematic way of keeping an infant's health on record until birth records started being collected. But since compulsory education laws kept children under the arm of the state, school age was the most convenient age to reach them.

It was also not unusual for the Board of Health to start with the school children to gain trust within the family. For example, Dr. S. Josephine Baker found that one of the best ways to ensure that parents would submit to having their babies immunized against diphtheria was to immunize their school-age children first. The doctors and nurses knew that the risk for diphtheria was most severe between the ages of six months and two years, but they suspected that parents would be more likely to allow the immunity test, and provide vaccinations if necessary, for their older children rather than their infants. Once the older child came through unharmed, and was convinced that the vaccine did indeed protect against the disease, they were ready to allow it in their younger children as well.¹³

Parents had varied responses to the nurses and the home visits. It was difficult to get some parents to treat their children's illnesses; some responded with inaction, others rejected

¹³ S. Josephine Baker, *Fighting for Life*, Reprinted with historical introduction, Huntington, N.Y.: R. E. Krieger Pub. Com 1980 (New York: Macmillan Co., 1939), 153.

entirely the involvement of the school in the health of their children. This was evident in some of the letters that nurses received from irritated parents. One boy was sent home in need of a bath, and his indignant mother responded quickly with a letter for the school nurse: “Dear Teacher, Ikey ain’t no rose. Don’t smell him—learn him.” Another, apparently listing all of the defects the nurse had asked his parents to treat, said: “Dear Nurse: As for his nose, it don’t need it. As for his tonsils, he was born with them. As for his teeth, he’ll get new ones. Please mind your own business.”¹⁴ Some parents clearly thought the nurse was interfering with their own authority over their children.¹⁵ Adele Shaw, journalist for *The World’s Work*, trailed a nurse on her rounds, including the home visits, and reported on what she witnessed. Shaw remarked on the difficult home conditions of some of the children, including violent and intractable parents. She made sure to note that many parents still considered their children mainly as financial investments who could contribute to the household income, and resisted having their children in school at all.¹⁶

The visiting nurse service responded to calls or to referrals from doctors, or from other patients who noted a need in one of their own neighbors. Which is to say, Lillian Wald and her first fellow nurse, Mary Brewster, had worked hard to be welcome in any home and never a nuisance. But school nurses were never called to the home at the behest of the parents, and they would sometimes have to be obtrusive and bothersome in order to get action on the part of guardians. The nurse was not an enforcer: although she could report to other agencies, she could not force parents to get medical treatment for their children; the most she could do was pester. And sometimes she had to. Nurses thus required the utmost in courteousness and affability in order to persuade parents to act.

¹⁴ Ibid., 147.

¹⁵ Rogers Struthers, *The School Nurse*, 71.

¹⁶ Shaw, “The True Character of New York Public Schools.”

For the most part, however, parents listened to and appreciated the nurse. Shaw wrote, “The house-to-house visits that fill the nurses’ afternoons and Saturdays are a delicate and difficult task. Mothers are taught, and many are glad to learn.”¹⁷ Rogers, too, felt that overall, mothers were “interested and make every effort to do exactly as they [were] requested,” and she reported that children would pass on their mothers’ gratitude to her.¹⁸ Whether or not we can trust Rogers’ understanding of how parents viewed her, the decrease in the rates of minor but persistent maladies such as head lice certainly indicated some cooperation on the part of parents, which could not have been achieved in any other way but through constant attention.

The nurses worked fifty weeks a year, including Saturdays, for only seventy-five dollars a month. How much the nurses were paid was repeated on many occasions, not only to remark on how little it was for such difficult work, but also for the profound impact that it carried for so little capital. Adele Shaw sarcastically noted the low pay of the nurses when she reported that during the first year of school nursing, the city of New York paid “this munificent sum to thirty women to take care of nearly 500,000 children.”¹⁹ The pay level seemed especially insulting given that school nursing was a “severe service demanding the rarest qualities.” If anyone objected to having to pay more taxes for additional school activities, Shaw was clear that the cost was very low for such an important service. She claimed that it was far and beyond the most important public health initiative affecting children. “I have given disproportionate time to this single phase of the school work because it is more effective in preventing the spread of disease than are even clean streets and fresh air. In no other way can the children who are neglected in

¹⁷ Ibid.

¹⁸ Rogers, “School Nursing in New York City,” 449.

¹⁹ Shaw, “The True Character of New York Public Schools.”

their own homes be kept from communicating their diseases to other homes, and *so long as a few schools have nurses and the rest have not, equal protection is not afforded to all.*"²⁰

For school age children, one of the main conditions that nurses faced in the homes was that of *pediculosis capitis*, usually shortened to pediculosis, and more commonly known as head lice; it was a scientific term for an unscientific obsession. Lice was a chronic condition that required thoroughness and vigilance to eliminate and keep at bay, and absolutely required the participation and cooperation of mothers. Whatever work was done at school could easily be undone at home through reinfestation from a sibling or parent, or from the linens, combs and brushes. Jacob Sobel, M.D. and a Borough Chief of the Bureau of Child Hygiene, submitted a paper to the *New York Medical Journal* on the subject of head lice in 1913. As Dr. Sobel wrote, "*Pediculosis capitis is a problem of the home, for the home, and by the home.*"²¹

But why did nurses and doctors treat the issue so seriously, when it was so prevalent that most parents considered it a fact of life? Dr. Sobel outlined the reasons for the time and effort spent on pediculosis. Some of his arguments were rather circular, revealing the social judgments that came into play as much as the medical ones. For example, he credited both the school exclusions and the humiliation as reasons to focus so much time and energy on lice, when these problems could both have been considered a result of over-attention to the condition. Nevertheless, this paper was unique in giving a perspective on why head lice was so important as a condition rather than just outlining suggestions for how to treat it.

²⁰ Ibid. Italics in original.

²¹ Jacob Sobel, "Pediculosis Capitis Among School Children," in *Department of Health Reprint Series*, vol. 12, 1913, 12. Italics in the original.

Even though it had not been proven that lice were vectors of disease, Sobel inferred the possibility from the fact that many other insects and pests most certainly had been determined to cause very serious illnesses. He linked its cousin, the body louse, to typhus, and the fly to polio, typhoid, and tuberculosis; the flea to the bubonic plague; the mosquito to malaria and yellow fever. As long as it was unclear what kind of carriers lice might be, it was best to be on the safe side.

Sobel also showed concern for children's comfort. Undoubtedly, Sobel was correct to remark that this condition was an underlying and constant irritation for children and that it affected the happiness of children and their success in the classroom. "Pediculosis of the scalp disturbs the general health by causing itching, restlessness, insomnia, irritability of the mind and body and as a result of all this anemia and a general lowering of the body tone."²² In essence, the itching drove kids nuts, which ultimately affected their physical condition. And worse than that, this annoying pest was contagious, and interrupted everyone else's work as well.

A chronic case of head lice—which all cases were likely to become without treatment—could result in not just annoyance, but infections from the persistent scratching and resulting sores.²³ Sobel pointed out that the lice could cause other skin conditions as well, blaming the pests as the roots of a list of additional ailments. "Pediculosis capitis acts as an indirect causative agent of local and general pus infections, glandular involvement with subsequent suppuration and scarring, and possible predisposition to tuberculosis adenitis; it often means secondary impetigo contagiosa, dermatitis, furunculosis, eczema, ulceration, folliculitis, and plica

²² Ibid., 3.

²³ Rogers Struthers, *The School Nurse*, 171–172.

polonica.”²⁴ Lice looked very serious indeed. Thus, medical inspectors and nurses had health and well-being on their minds when they attacked head lice with such relentlessness.

That said, however, the primary reason for the concern was probably only tangentially related to the illnesses that head lice might *cause*, but rather that lice was a *symptom* of what they considered a far more serious problem of hygiene, cleanliness, and lifestyle. Lice was linked with filthiness and poverty, and in some ways, the obsession was a remnant of a more miasmatic system of disease theory, no matter how doctors and nurses might try to wrap it in the more modern and scientific germ theory. Sobel’s number one reason, listed first among all of these others, was that it was a “cosmetic” issue. “Pediculosis in any form is a dirt disease and, as such, is a forerunner of illness in its many phases. It is an index of the family’s cleanliness, of the parent’s care and attention, and often of the character of the school child. The presence of pediculi in the home, on members of the family, or on the school child may be an accident; their continuance means a disregard for cleanliness and health.”²⁵

Sobel struck an odd balance between recognizing the social and environmental conditions that might predispose children to catching head lice, yet still stigmatizing those who didn’t rid themselves of it. All children might catch head lice, but an unwillingness to treat it and solve the underlying causes was certainly a failure of character. According to Dr. Baker, nurses performed a kind of “home-missionary work” to “turn the condition into a disgrace.”²⁶ They taught entire families how to use shampoo and a fine-tooth comb in their hair, then to soak hair in kerosene to kill nits. One memoirist certainly hit on the relationship between a religious zeal and the

²⁴ Sobel, “Pediculosis Capitis Among School Children,” 2–3.

²⁵ Ibid., 2.

²⁶ Baker, *Fighting for Life*, 80–81.

vigorous efforts against head lice as she recalled her own treatment as a child on the Lower East Side:

“I disliked washing my head in kerosene oil. It was slimy to the touch, even though the hair did acquire a certain silky sleekiness after the ablution. So I imagined, after I had washed my head in the smelly solution and was lying in bed, that the angels sent from God smiled down upon me. They usually stuck their heads through the hall window, because it was cleaner than the narrow one that faced the skylight. Sometimes I substituted the head of a mythical lover. But I felt just as sure that God was pleased with me for having washed my head in kerosene water.”²⁷

Nurses worked tirelessly throughout the school year, and in the summer months, the Department of Health utilized their home visiting experience and skill in a larger city effort to combat infant mortality. In 1887, a group of doctors founded the Summer Corps, and with the assistance of a few visiting nurses from the Department of Public Health, would visit babies.²⁸ But once NYC schools had this new team of nurses at their disposal, they were put to use immediately in the summer of 1903 to “systematically” visit every child that had been born the previous year in order to help them survive that “first precarious summer.”²⁹ The school nurses assisted the

²⁷ Bella Cohen Spewack, *Streets: A Memoir of the Lower East Side* (New York: Feminist Press, 1995), 45.

²⁸ John Duffy, *A History of Public Health in New York City, 1866-1966* (New York, Russell Sage Foundation, 1974); C.-E. A. Winslow, *The Life of Herman M. Biggs* (Philadelphia: Lea & Febiger, 1929); *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research* (New York: Bureau of Municipal Research, 1908); Lina L. Rogers, “Summer Care of Babies in New York City,” *The American Journal of Nursing* 8, no. 12 (September 1908): 1000.

²⁹ Annie M. Brainard, *The Evolution of Public Health Nursing*, Reprint (Originally published Philadelphia: Saunders, 1922), *The History of American Nursing* (New York: Garland Publishing, Inc, 1985), 286.

physicians of the Summer Corps, “instructing the mothers in infant feeding and demonstrating methods of clothing, bathing and airing.”³⁰

It was certainly no secret that child death was a common experience for many mothers; throughout most of the eighteenth and nineteenth centuries, 25 percent of all children born in the United States died before the age of five, and a third of all children died by the age of ten.³¹ The number of infant deaths (under one year) was also very high. By 1900, six percent of babies died before the age of one month, and another seven percent did not reach their first birthday.³² Put another way, “Of all the people who died in New York City every year, a third were children under five years of age and a fifth were babies less than a year old. It was the babies and small children who never really had a chance to live, who swelled the death rate to fantastically macabre proportions.”³³

The creation of milk stations was the earliest means through which reformers attempted to educate mothers to prevent infant mortality.³⁴ Before pasteurization and refrigeration, milk was transported from farms outside the city, then brought to grocers and pushcart sellers, and finally to mothers. This chain of transportation required proper handling at each step, and keeping milk

³⁰ Winslow, *The Life of Herman M. Biggs*, 187.

³¹ Richard A. Meckel, “Levels and Trends of Death and Disease in Childhood, 1620 to Present,” in *Children and Youth in Sickness and in Health: A Historical Handbook and Guide*, ed. Janet Golden, Richard A. Meckel, and Heather Munro Prescott (Westport, Conn: Greenwood Press, 2004), 4.

³² *Ibid.*, 14.

³³ Baker, *Fighting for Life*, 10.

³⁴ For milk stations and the fight against infant mortality, see: Meckel, *Save the Babies*; Wolf, *Don't Kill Your Baby*. Wolf found that public health agents could not ignore that safe cow's milk was crucial to helping babies survive and therefore they spent considerable time and resources improving the quality and safety, but this sent out contradictory messages to mothers. “These latter efforts altered the perception of cows' milk from a potentially dangerous substance to a safe and beneficial one, and paradoxically predisposed even more women to feed their babies cows' milk”(4).

on ice during the summer months was crucially important. Some providers were attentive to the quality of their milk, but others were known to be careless, or even to deliberately deliver tainted milk. But even when farmers and grocers were conscientious, mothers didn't always know how to keep the milk safe. Some women would just hang the open pails of milk on the fire escape, a solution that worked well in the winter, but could be disastrous in the summer.³⁵ To combat this problem, the first milk station was established in Rochester, New York in 1897. As the city's department of health was taking measures to regulate providers, they also wanted to educate mothers on the dangers of bad milk and to provide them with a safe supply. They distributed a pamphlet in three languages that told mothers how to look after their babies during the summer months.³⁶ The Health Commissioner of the city attributed the success of the milk stations not to the milk itself, but to "the education that went out with the milk through the nurse..."³⁷

This idea spread to other cities, and milk stations were used as infant dispensaries. According to historian Howard Markel, they were the "birthplace" of the well baby examination, "the primary site of medical care for the majority of first generation immigrant children in American cities during the Progressive Era."³⁸ Henry Street Settlement House opened a milk station in 1903 that provided high-grade milk from a private dairy and educated mothers how to keep milk clean. Wald trusted in the competence of mothers to take care of their own children if given the proper resources. She called infant mortality a "social disease" that was created by

³⁵ Howard Markel, "Caring for the Foreign Born: The Health of Immigrant Children in the United States, 1890-1925," *Archives of Pediatrics & Adolescent Medicine* 152, no. 10 (October 1, 1998): 1025.

³⁶ U.S. Department of Health, Education, and Welfare and Public Health Service Health Services Administration Bureau of Community Health Services, *Child Health in America* (Washington, D.C.: Government Printing Office, 1976), 19.

³⁷ Wald, *The House on Henry Street*, 56.

³⁸ Markel, "Caring for the Foreign Born," 1025.

“poverty and ignorance.” These deaths were entirely preventable. Babies could be saved “through the intelligence of mothers.”³⁹

In 1908, the Bureau of Municipal Research engaged Dr. Baker to investigate the causes of New York’s high death rate, and she was provisionally given the position of Chief of the Bureau of Child Hygiene as an unofficial post with no power or funding. After the Conference on the Hot Weather Care of Babies in May of 1908, the Summer Corps was expanded and joined with other community agencies to provide more comprehensive and organized care in the prevention of infant mortality. As a part of this research, Baker utilized the Summer Corps of nurses to visit mothers much sooner; nurses obtained the names and addresses of all of the babies whose births were recorded within the previous three months.⁴⁰ There were participants from various agencies and the city was separated into districts, each one assigned a single nurse to be responsible for babies in that area.

Doctors also took on the more public role of education by “conducting educational lectures and instructions in vacation schools, playgrounds and recreation centers,” while nurses took on the education of individual mothers within homes.⁴¹ Nurses instructed the mothers of reported newborns, and doctors visited the sick babies who had been referred by the nurses. The nurses asked a series of questions in order to determine the health of the mother and child, and the conditions in the environment; nurses were also determining the knowledge of the mother and her ability to prevent illness. The nurses asked about the kind of care that the mother had received during parturition, such as whether she had a doctor or a midwife at delivery and if the

³⁹ Wald, *The House on Henry Street*, 54–55.

⁴⁰ Rogers, “Summer Care of Babies in New York City,” 1000.

⁴¹ *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research*, 28–29.

baby had any ailments at birth. She asked how often the baby was fed, whether or not the mother was breastfeeding, and if so, the details of the mother's diet.⁴² If the child was receiving what the nurses called "artificial feeding," they recorded whether the family could keep it on ice, and asked questions about the regularity of the feedings and the cleanliness and quality of both the milk product and the bottles.⁴³ They requested the health and weight of the baby and asked how and how often it was bathed.⁴⁴ The nurses asked about the employment of the mother, who cared for the baby during the daytime, and then investigated the cleanliness of the rooms. Finally, nurses wanted to know what kind of outings the baby had and how often.⁴⁵

Each nurse carried with her sets of instructions, both for general care and more specific problems or issues. The nurse who was assigned to that district later made return visits to make sure that instructions were being followed. Nurses also connected families with other agencies in the neighborhood; for example, when cases of severe poverty were found, they referred the

⁴² Apple, *Mothers and Medicine: A Social History of Infant Feeding 1890-1950*; Wolf, *Don't Kill Your Baby*. The two most important books on infant feeding are Apple's *Mothers and Medicine* and Wolf's *Don't Kill Your Baby*. Although both studied the same time period and essentially the same issue, they came at the question differently. Apple explored why women were beginning to bottle feed when the evidence clearly pointed to breastfeeding as a better way to improve the chances for babies' lives. She found that the more respect and authority that physicians gained in parental decisions, the more mothers valued the imprimatur of science that modern, commercial milk substitutes proffered. She argued that by the 1940s, it was the preferred method of feeding for American mothers. Wolf instead asked why women were breastfeeding, and she came to different conclusions. She argued that doctors were actually responding to women's preference for bottle-feeding that was clear by the 1910s. Mothers questioned breastfeeding's efficiency as well as its influence on marriage and health, and this trend spurred the infant food industry rather than the other way around.

⁴³ Wolf explained that the term "artificial feeding" was not neutral; it was intended, and understood, as a "damning phrase." Wolf, *Don't Kill Your Baby*, 3-4.

⁴⁴ By the 1880s, doctors were using weight as an indicator of a baby's overall health in infant welfare clinics. By 1910, weighing would extend to school-age children. Jeffrey P. Brosco, "Weight Charts and Well-Child Care: How the Pediatrician Became the Expert in Child Health," *Archives of Pediatrics & Adolescent Medicine* 155 (December 2001).

⁴⁵ Rogers, "Summer Care of Babies in New York City," 1000.

families to a relief society. They also handed out lists of milk depots and children's aids societies from whom families could get additional instructions.⁴⁶

In her 1908 report, Lina Rogers did not remark on any recalcitrance on the part of mothers receiving this instruction. In fact, in earlier discussions of home visiting, Rogers usually remarked on the willingness and desire of mothers to keep their babies healthy and to learn the best means to do so. Baker agreed. "In my experience, nearly all mothers are fine when they are given half a chance to know how to be. As soon as they saw that their babies were flourishing, despite the cruelly hot weather, they became our most efficient aides."⁴⁷

The instructions that were given by the nurses were elaborated to become the booklet that Dr. Baker had created for distribution as part of the Department of Health's series of Keep Well Leaflets. Baker published one such leaflet in 1918 under the title "Talks with Mothers."⁴⁸ The most important feature of the introduction to these talks was the emphasis on trusting doctors and nurses—professionals—rather than other women.⁴⁹ Baker recommended that a mother never delay in calling upon a doctor when a baby was ill. Not surprisingly, many of the mothers hoped that the illness might end on its own without the great expense of scarce financial resources;

⁴⁶ The instructions and lists of milk depots that were given out can be found in the section on the "Summer Care of Babies" in the annual report of that year. New York (N. Y.). Board of Health, *Annual Report of the Department of Health of the City of New York for the Year Ending December 31, 1908* (New York: Martin & Brown Co., 1909), 326–331.

⁴⁷ Baker, *Fighting for Life*, 86.

⁴⁸ S. Josephine Baker, *Talks With Mothers*, Keep Well Leaflets 12 (New York City: Department of Health, 1918).

⁴⁹ Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries"; Apple, *Perfect Motherhood*; Apple, *Mothers and Medicine: A Social History of Infant Feeding 1890-1950*. Critics did not fail to remark on these unmarried and childless women giving advice on the proper care of children—an issue that was particularly clear when the Sheppard-Towner Act was debated in Congress. U.S. Department of Health, Education, and Welfare and Public Health Service Health Services Administration Bureau of Community Health Services, *Child Health in America*, 29.

Baker, however, insisted that only a doctor could adequately advise on whether a baby was seriously ill or if it was merely a normal stage of infancy. Baker portrayed other women as purveyors of superstition and bad advice.⁵⁰ The suggestions other women offered may have been good advice for one case that the doctor treated, but every baby was different and only a doctor could determine the nature of an illness and its best course of treatment. What worked for one baby “may be poison for yours.”⁵¹

Another reason that neighbor women might have been wrong was that their advice was simply outdated. As Baker told mothers: “Most of your neighbors are likely to have old-fashioned ideas, particularly the older ones, whom you are most likely to ask for advice. Our grandmothers used to believe in rocking babies, walking with them, jumping them up and down, clothing them too warmly, feeding them all sorts of things when they were very little, letting them taste of everything, giving them comforters to suck and keep them quiet, etc., and a great many of their babies died, a great many more than die today, since doctors and nurses have been learning better ways to take care of babies and teaching them to mothers.”⁵² Women were supposed to trust new scientific methods, and the professionals who practiced them, rather than the anecdotal experience or superstitions that have been passed down by other women. Still implicit in this discussion was that the neighbors, both old and young, whom mothers might consult were more than likely from the “Old Country”—whatever the actual land or nationality that may have previously claimed them.

⁵⁰ For a thorough listing of all of the superstitions and beliefs that doctors encountered in the tenements: Jacob Sobel, *Prejudices and Superstitions Met with in Medical School Inspection.*, New York City. Health Dept. Reprint Series; 13; ([New York, 1913).

⁵¹ Baker, *Talks With Mothers*, 2.

⁵² *Ibid.*, 2–3.

But Baker was not insensitive to the financial needs of these impoverished mothers. She advised them to find a Milk Station as a place to get advice, and if they couldn't afford a doctor to call the Board of Health "and they will help you out." Baker was hoping to educate mothers the basics of home care, but also to provide information on the resources available in the community. Furthermore, Baker emphasized that the purpose of her visits and talks, as well as the purpose of the milk stations, was to keep babies well, not just treat illness. "But don't wait until baby is sick before asking for advice. We have opened the Milk Stations to keep babies well."

Baker gave mothers a sense of when to call the doctor if a baby was already sick. Important to note about this list of complaints—fever, vomiting, lack of appetite, cough—was that although Baker mentioned the various symptoms of illnesses, she did not name the illnesses themselves. It becomes clear even through her rhetoric that a mother should not diagnose the illness—only the doctor or nurse could do that. This was not an effort to educate women about their own health or that of their babies, but rather to teach them to trust the role of doctors. "If you can't get to a doctor of your own go to the nearest milk station or dispensary or call up the Board of Health and *they will take care of you.*"⁵³ These directions were patronizing in the sense that they gave advice, but not knowledge. Women were not educated on the various kinds of illnesses that might strike a baby, but rather the behaviors that might cause illness and the symptoms that might reveal them. Mothers were not taught to take control—to educate themselves—but to surrender control—to trust the experts, who will tell you "just what to do."

This idea was reinforced by Baker's discussion of the proper feeding of children. Baker told mothers that it was best to breastfeed babies, but even as she advocated for this "natural"

⁵³ Ibid., 6. Emphasis mine.

method of infant feeding, she encouraged mothers to go to the Milk Stations to learn how to feed their babies on a regular schedule, how much to feed them (too much was worse than too little) and to properly take care of themselves—cleaning nipples before and after a feed, as well as getting proper nutrition and sleep. Baker admitted that some mothers could not nurse their babies, but even this decision was not the mother's, but the doctor's.⁵⁴ In the case of women who were unable to breastfeed—"I am sorry for you," Baker said—Baker at least told women how to choose quality milk and to keep it safe for baby's consumption, but not before thoroughly chastising those women who chose not to breastfeed for their own reasons. "But some mothers are too lazy or selfish to nurse their little ones. They had rather run the risk of killing their child than be bothered with nursing. They are not natural mothers. I can't help them. They don't deserve help."⁵⁵

But despite how harsh and judgmental we might find Baker, her methods were very successful in reducing infant mortality. The proof was in the numbers; there were 1200 fewer deaths in that summer than in the previous one.⁵⁶ On the basis of the pilot program's success, the Division of Child Hygiene was created with S. Josephine Baker as its Chief, and the efforts to prevent infant mortality were redoubled. The number of infant deaths dropped from one in seven to one in fourteen in Baker's first thirteen years of service as the Director of the Bureau of Child Hygiene of the New York Department of Health.⁵⁷ Baker would transform child health care in

⁵⁴ Ibid., 7.

⁵⁵ Ibid.

⁵⁶ Baker, *Fighting for Life*, 86. The outline and results of this study were published here: *A Bureau of Child Hygiene Co-Operative Studies and Experiments by the Department of Health of the City of New York and the Bureau of Municipal Research*.

⁵⁷ Molly Ladd-Taylor, "Women's Health and Public Policy," in *Women, Health, and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New York: Garland Pub, 1990), 399.

New York City, and this bureau would be the model for agencies in other states and for the Federal Children's Bureau that would be established in 1912.

While visiting nurses, and nurses as a profession, had already been working to treat the whole person and to work toward prevention rather than cure, doctors, and Departments of Health, were catching on. According to Baker, when the idea came to her to treat babies when they were already well, rather than waiting until they were sick, she found it a groundbreaking idea. Baker described her own epiphany: "If mothers could be taught what to do, most of these squalid tragedies need never happen. The way to keep babies from dying from disease, it struck me suddenly, was to keep them from falling ill. Healthy people didn't die."⁵⁸ Baker continued: "At that time health departments went entirely on the principle that there was no point in doing much until something had happened. If a person fell ill with a contagious disease, you quarantined him; ... It was all after-the-fact effort—locking the stable door after the horse was stolen."⁵⁹ This experiment by the Department of Health to provide care for babies may seem like common sense, but preventive care was still not the priority of the agency before 1908; it had to be proven through research. The reports of the Bureau of Municipal Research convinced the Board of Estimate and Apportionment that "money could be legally appropriated to care for well people."⁶⁰ It may have been a revolutionary idea for doctors, but it was a practice that nurses had already trail blazed.

Although preventive health became a priority for the Department of Health, and the creation of the Bureau of Child Hygiene was an important step in improving child health throughout the city, there were also some losses. Lina Rogers left New York City in 1908-1909,

⁵⁸ Baker, *Fighting for Life*, 83.

⁵⁹ Ibid., 84.

⁶⁰ Ibid., 86.

the year that Bureau was established. We don't know the exact reasons that Rogers left, but it appears that it was not on the best of terms with the city. The *Canadian Nurse* bitterly reported her departure, but only described the conflict in vague terms.

“Lina Rogers... who is a pioneer and a bright and shining example among school nurses, resigned her position in New York under the Board of Health on October 1st. Miss Rogers organized the work of school nurses in New York six years ago, and perhaps no one in the world knows quite as much about the school nurse and her work as Miss Rogers. The reason of her resignation reflects credit upon her and discredit upon others who shall be nameless. Miss Rogers has had several good appointments offered to her already. We have a great hope that she may come to Toronto, but, wherever she goes, our best wishes will go with her.”⁶¹

When the Division of Child Hygiene was created, medical inspection was put under its control, and there was a restructuring of the system. Priorities shifted more toward the prevention of contagious diseases and the detection of defects and abnormalities rather than preventive health and education. This bureaucratic overhaul put child health firmly under the auspices of the Board of Health, while Rogers adamantly believed that school medical inspection should be under the control of the Board of Education. This is a point she would argue repeatedly throughout her life, and a fight she would have to have again with the Toronto Board of Health in 1916.

Rogers left New York City to go to Pueblo, Colorado, where she was paid by the Board of Education. At the time, she considered it a “most interesting experiment” in whether or not a school medical inspection program would be more successful under a Board of Education than under a Department of Health, since it was “still a matter of doubt.”⁶² In the end, however, she found the Pueblo system to be “infinitely better... in every way.” The priorities of the two divisions were very different. The Board of Education had complete control over the schools,

⁶¹ Canadian National Association of Trained Nurses, “Personal,” *The Canadian Nurse: A Monthly Journal for the Nursing Profession in Canada* IV (1908): 564.

⁶² *Ibid.*, 626.

“and the Principals in the schools feel if you belong to their department they can ask you to do so much more, and can enlarge.”⁶³

Despite the fact that nurses had led the way in preventive health measures, and that it was a great success to have those implemented on the municipal level, doctors still had a more limited view that focused on illness and defect rather than on viewing the child as a context of his environment and his education. The Department of Education allowed nurses to take up “anything that has to do with the health of the child.” In contrast, the Department of Health was primarily concerned with the “contagious end” of things.⁶⁴

Nurses were regularly making home visits to educate mothers, but the nurse was not the only means of transmission of this type of health and childcare information: children themselves were meant to educate their parents on what they learned in school. The school nurse had a responsibility to educate the child in health, but this information was also expected to reach into the families. One of the ways this was to be accomplished was through Little Mothers’ Clubs.⁶⁵

John Spargo had written about the phenomenon of the “little mother” in *The Bitter Cry of the Children*.⁶⁶ He was disgusted with the common sight in the slums of the elder sibling who was left to tend to the baby while her mother worked. The babies had runny noses and sores,

⁶³ Rogers, Lina, “Medical Inspection of Schools, Proceedings of the Annual Meeting of the Graduate Nurses’ Association of Ontario, Held in the Residence of the Sick Children’s Hospital, on Tuesday, May 24th, 1910,” *The Canadian Nurse* VI, no. 8 (August 1910): 334–36.

⁶⁴ Ibid.

⁶⁵ John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990), 208–209; Meckel, *Save the Babies*, 144–145; Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca, NY: Cornell University Press, 1995), 64–66.

⁶⁶ John Spargo, *The Bitter Cry of the Children* (New York: Macmillan, 1906).

dirty or ill-fitting clothes, and both the older and younger child were frustrated and miserable, or so the story went; and “...without proper knowledge,” especially when it came to feeding and care in the summer, these untrained caregivers were a threat to the health of babies.⁶⁷ Lina Rogers exclaimed, “Could we expect anything from these children but untidiness, uncleanness, loose habits, ill-health, dishonesty, crime, and immorality!”⁶⁸

Spargo didn’t coin the term “little mother”—his 1906 book post-dated many other articles that describe the occurrence—but he may have brought it to wider attention. The little mother was an oft-used trope in alarmist news accounts of the 1890s and 1900s, and represented a fundamental clash in immigrant and middle-class beliefs about the role of the child within the family. Most immigrant families considered children to be part of the economic contribution to the household, while middle class reformers had already adopted the sentimental view of childhood that would become more prevalent in the twentieth century. It was during this era, as Viviana Zelizer showed, that children were redefined from being “useful” contributors to the family economy to financially “useless”—and in fact quite costly— but emotionally “priceless” beings.⁶⁹ But many reformers simply could not contend with the necessity of work in immigrant families in which everyone had to contribute in order to simply survive.⁷⁰

The “sacralization” of the child, as Zelizer termed it, was closely tied to expectations for middle class motherhood. Homes were supposed to be child-centered; women were expected to

⁶⁷ S. Josephine Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, Monograph Series / Department of Health of the City of New York; No. 4; (New York: Dept. of Health of the City of New York, 1915), 71.

⁶⁸ Rogers Struthers, *The School Nurse*, 118.

⁶⁹ Viviana A. Rotman Zelizer, *Pricing the Priceless Child: The Changing Social Value of Children* (New York: Basic Books, 1985).

⁷⁰ Ewen, *Immigrant Women in the Land of Dollars*, 85; Steven Mintz, *Huck’s Raft: A History of American Childhood* (Cambridge, Mass.: Belknap Press of Harvard University Press, 2006).

stay at home to take care of domestic tasks rather than earning wages for work so that they had more time to nurture and guard their children. Since the standard of the New World was one of a family wage economy in which men supported the family and women and children were sequestered from work, some middle class reformers judged immigrant women harshly for participating in the labor market and not protecting their children from both work and the dangers of the streets. Complaints about the existence of the “little mother” could seem like implicit jabs at the actual mother.

Reformers also felt that children had rights as individuals that outweighed the need for obligation to family.⁷¹ Most immigrants had a strong sense of the family as a unit, and that individual members might have to sacrifice for others. While patriarchal societies emphasized the need for children to serve their parents, some reformers felt that they must release children from this antiquated understanding of their place. These reformers thought that parents should put their emotional and financial resources toward the wellbeing of their children, rather than the other way around. Prominent social worker Edward Devine even wrote that the goal of settlement work was “to bring forward the individual to insist that living human beings shall not be sacrifices to a tradition of family solidarity.”⁷² Just as some women reformers had pulled away from their own “family claim,” they worked to promote these ideas of individualism among others as well.

Middle-class reformers thus encouraged immigrants to maintain a household in the way that they might, but immigrant mothers did not have the financial ability or necessarily the ideology that allowed for this kind of lifestyle. While the middle-class space of a home was

⁷¹ Ewen, *Immigrant Women in the Land of Dollars*.

⁷² Quoted in *Ibid.*, 87.

idealized as having separate rooms, high standards for cleanliness and regulation, and kept primarily for the nuclear family, immigrant households were often multi-generational, and had many family members sleeping in the same room and even sharing mattresses. The household also often included extended families, or even boarders to share the burden of high rents. The immigrant household, in sum, could not live up to middle class expectations.

Reformers had also begun to see play as a fundamental right belonging to children.⁷³ Using a new scientific understanding of child development popularized by G. Stanley Hall and John Dewey, in addition to a dawning of a kind of environmental awareness, they argued that it was not just a way to pass the time, to keep children safely out of the way while the parents worked; it was a requirement for children, and they needed the time and space to fulfill that right.⁷⁴ The activity of play itself was natural, necessary, and deserved by all children; without it, their energies would be channeled into delinquency and gang activity. Lillian Wald lauded the widening recognition of “child’s right to play... as an integral part of his claim upon the state.”⁷⁵

Lillian Wald created a playground in the backyard of Henry Street right away upon moving to the residence, and it was very quickly in high demand among the children and families of the neighborhood. Even the teenagers would find their way there in the evenings to socialize among their peers. The residents of Henry Street took down the baby hammocks and put up Japanese lanterns for the youth who had spent their days at work to have an evening of

⁷³ Wald, *The House on Henry Street*, 96; Riis, Jacob A., “The Rights of Children,” *Charities* VII, no. 2 (July 13, 1901): 47–48. Often right to play rhetoric played on fears that unoccupied children without the chance to expend their natural energy would channel it in to crime. The Fresh Air Fund provided some children the opportunity to experience nature outside of cities. Barry Ross Harrison Muchnick, “Nature’s Republic: Fresh Air Reform and The Moral Ecology of Citizenship in Turn of the Century America” (Ph.D., Yale University, 2010).

⁷⁴ Smuts and Smuts, *Science in the Service of Children, 1893-1935*.

⁷⁵ Wald, *The House on Henry Street*, 96.

fun and relaxation. When the play area got too full, little girls soon realized that the “little mothers” got priority, and would bring their siblings along in order to jump the queue. If a girl didn’t have a sibling, she would even borrow a baby from a neighbor so that she would have a greater shot at the chance to play.

Lillian Betts wrote a brief history of the playgrounds for children in *Outlook* in August of 1896, and revealed the high demand for even the most pathetic of spaces.⁷⁶ College Settlement opened up their yard to the children of the neighborhood, which “was about twenty-five by thirty-five feet, was entirely surrounded by high brick walls, and contained one sickly tree.” Even for this measly piece of ground, the settlement had to supply tickets to children so that they could scatter the numbers throughout the day. Clearly, more spaces were needed in the neighborhood to give some recreation to children, youth, and families if there were lines outside the door waiting to get a chance to enter.

In 1898, a group formed the Outdoor Recreation League and the settlement houses joined in to advocate for more public spaces for children to play. The city, during a brief period with a sympathetic administration, bought a sizeable lot for the purpose, and razed some dilapidated tenement houses. After a struggle through an inept Tammany administration that left the space ugly and unoccupied for at least a season, Wald bent the friendly ear of the Commissioner of Health, and he used his influence to determine that the now abandoned lot was a health menace. He secured funds to fill and enclose the area, and “the Outdoor Recreation League was able to demonstrate the value of playgrounds.”⁷⁷ In 1902, under the administration of Seth Low, the

⁷⁶ Lillian W. Betts, “The Children’s Playgrounds,” *Outlook*, August 22, 1896.

⁷⁷ Wald, *The House on Henry Street*, 86.

Board of Estimate and Apportionment funded the creation of Seward Park, New York's first municipal park.

Wald even felt that the streets needed to be liberated for children's play, and that the police spent too much time being a menace to children rather than encouraging their fun activities. Wald argued that if the police would lighten up a bit, children would see them as "protectors and guardians" rather than as enemies. Betts confirmed that children were harassed in the streets by police officers that constantly chased children away from their games. "The street did not represent freedom, for there the neighborhood bully could make life miserable for the children, and the policeman, that terror of child life in such a city as New York, with his never-ceasing cry of 'Move on,' appeared just when the game was at its height."⁷⁸ So reformers led groups of children to distant parks where they could spend the day playing baseball.

It is within this context that we can think about the trope of the little mother and its prevalence in the decades preceding the invention of "little mothers' clubs." In 1891 a *New York Times* article reported the founding, nearly a year before, of a "Little Mothers Aid Society" to help "a very pathetic subdivision of the large class of the city's poor."⁷⁹ Little mothers could be recognized by their neglect, and a physical presentation that was starkly different from the doll-like feminine creatures that were so prized among the middle class. "Their thin, wan faces, warped frames, tattered and scanty garments, and prematurely aged appearance tells the story of their wretched lives."⁸⁰ In 1896, another article drew attention to their plight: "Little Mothers of the Slums: The Sad Lot of these Childish Caregivers Compels Pity" described a similar look. A

⁷⁸ Betts, "The Children's Playgrounds."

⁷⁹ "To Benefit the Little Mothers; An Organization That Has Much Good Work in View," *The New York Times*, June 7, 1891.

⁸⁰ Ibid.

child's body revealed "her endurance of privations and neglect, her prematurely old, wan, and pale face, showing half-fed nature..." These markers of physical deterioration also coded underlying and unseen characteristics, such as "inherent disease" and "ignorance."⁸¹

These descriptions pointed out the lack of differentiation between the lives of the children and their parents. These children lived unhappy lives that mirrored the adults around them. Just as their mothers couldn't live up to the bourgeois standards of female domesticity, their children could not live the precious childhoods valued by the same class. The little mother was described as just that, one living a life that replicated that of her mother, rather than relishing childhood as a sacred, separate time. "Everywhere where little children are found there is the little mother with her patience, her motherly care, her self-sacrifice..." wrote a journalist for *The New York Times*.⁸²

The days of young people were filled with drudgery and toil; children were burdened with worries and tasks, rather than leading carefree lives with free play or spending their days in school. "Upon them devolves the care of the home and the baby when the parents are absent at work, and of preparing the meals and attending to the fires."⁸³ And their lives had no variance from this routine of work. "From seven or eight to fourteen or fifteen they know no other life. When one baby grows out of their arms another is nearly always ready to take its place."⁸⁴ She was deprived of her innocence, left exposed to the dangers of the streets. After these years as a little mother, this pattern would only be extended to more labor in a shop or factory or as a domestic servant, implying a repeated cycle that would threaten the next generation as well.

⁸¹ "Little Mothers of the Slums; The Sad Lot of These Childish Caretakers Compels Pity," *The New York Times*, June 7, 1896.

⁸² Ibid.

⁸³ "To Benefit the Little Mothers; An Organization That Has Much Good Work in View."

⁸⁴ Ibid.

While these reformer-journalists were making a case for the necessity of services for these women and children, that care required a great amount of pathos that perhaps made a mockery of the individuals suffering from these conditions: the wage-earning mothers, the delinquent waifs, and the little mothers. While these writers criticized the existence of the “little mother” as evidence of a harsh childhood, memoirists had their own accounts. Catharine Brody refuted that description, although she may have had more critical distance from the hysteria twenty years later. In fact, she felt that her childhood was quite free of chores and tasks, and “almost the only duty that devolved upon the girls was minding the current baby.” She thought it might have been worse for “the very poor” and that all of the concern over Little Mothers may have been justified, but as for her, “I do not remember that baby-tending was a laborious task to us.” The girls would park the babies in their carriages, and “spend long, chattering, comfortable afternoons” socializing and doing their embroidery together.⁸⁵

Bella Spewack, co-lyricist of the musical *Kiss Me Kate* and inventor of the Girl Scout Cookie, also grew up on the East Side; she didn’t remember the experience of being a “little mother” as nearly as carefree. “I fed, cleaned, and dressed the baby. I was with him all day and nearly all night. My baby brother slept in his carriage on the street while I watched, and in the house, my mother worked feverishly at her sewing. I would stay on the street until two in the morning, my head pillowed in my lap.”⁸⁶

But what to do about the little mother? Of course the social conditions that allowed the little mother to exist should be altered, but that did not solve the immediate problem. As Dr. Baker put it,

⁸⁵ Catharine Brody, “A New York Childhood,” *The American Mercury: A Monthly Review*, May 1928.

⁸⁶ Spewack, *Streets*, 80.

No one had to tell me about the little mother of the New York slum. ... But I could not dodge the issue by simply agreeing with Mr. Spargo's point that there should be no such thing as a little mother, innocently and ignorantly killing her thousands of children a year. That was not our slant on things. We could not afford the luxury of saying things should or should not be. We had to work realistically with the raw materials and situations at hand. Since thousands of poor families were in an economic situation which made the little mother necessary, we had to turn her into something that suited our purpose.⁸⁷

Little Mothers' Clubs were designed to teach health and hygiene methods to older girls who cared for babies in the effort to reduce the high rates of infant mortality. Started in 1910 by Dr. Baker after she read Spargo's book, they were not meant to teach first aid or any medical knowledge, and did not teach about the treatment of disease. The idea was to give girls "a simple and practical understanding of those things which are necessary to a home life for little children."⁸⁸

Dr. Baker called public school "the obvious point of contact" to reach these school-age girls who cared for other children.⁸⁹ "If the schools would install classes in practical child-hygiene—for whether little mothers or not, most of these girls would eventually become mothers in their own right—our problem would be solved." Initially Baker had hoped to get childcare classes as part of regular school instruction; this was not a completely outlandish request in a period in which public schools were starting to expand their programming outside the traditional 3 Rs, including night classes and vocational education. But the idea of childcare classes was too farfetched for the Board of Education at the time. When Baker went to make the request, she

⁸⁷ Baker, *Fighting for Life*, 132–133.

⁸⁸ New York (State) Department of Health, *Outlines for Organizing and Directing "Little Mothers' Leagues"* (Albany, N.Y.: New York State Dept. of Health Issued by Division of Child Hygiene, 1918).

⁸⁹ Baker, *Fighting for Life*, 133.

wrote that “the educational authorities would not even bother to laugh at me when I made the suggestion.”⁹⁰

Baker truly was in the vanguard with her efforts to include childcare courses within the regular school program. Home Economics was moving forward—“Domestic Economy” courses had existed at the college level in some universities since 1873, and the first conference on Home Economics had occurred in Lake Placid in 1899— but parenting was not on the program for another decade from when Baker suggested it for her schools. Since the home economists wanted to apply scientific principles to household living, they applied the sciences that were credible. The focus of the early practitioners, many of whom were trained in the physical sciences, was on nutrition and home sanitation.⁹¹ The behavioral sciences were still in their early stages, and childhood development courses wouldn’t catch on in Home Economics until the 1920s.⁹²

Although the Board of Education wouldn’t take on her project, she found a sympathetic principal who would. Margaret Knox of Public School No. 15 was the first to provide the space for a Little Mothers’ Club. Dr. Baker and the New York City nurses were the first to implement Little Mothers’ Clubs and to establish some general guidelines for how they could be taught, and they were quickly emulated throughout the United States.⁹³ The clubs were probably run differently depending on the location, but the theme of educating little girls in homemaking and

⁹⁰ Ibid. Sarah Stage and Virginia B. Vincenti, eds., *Rethinking Home Economics: Women and the History of a Profession* (Ithaca, N.Y.: Cornell University Press, 1997), 321–322.

⁹¹ Margaret W. Rossiter, *Women Scientists in America: Struggles and Strategies to 1940* (Baltimore: Johns Hopkins University Press, 1982).

⁹² Grant, Julia, “Modernizing Mothers: Home Economics and the Parent Education Movement, 1920-1945,” in *Rethinking Home Economics: Women and the History of a Profession*, ed. Sarah Stage and Virginia B. Vincenti (Ithaca, N.Y.: Cornell University Press, 1997), 55–74.

⁹³ “‘Little Mothers’ Club’ Learning to Care for ‘Babies’ Under City Direction,” *Chicago Daily Tribune* (1872-1922), November 19, 1911.

childrearing skills remained across the board. By the summer of 1914, there were 137 leagues in New York City with membership at 17, 638.⁹⁴ In 1915, 25,000 girls were enrolled.⁹⁵ By 1916, the New York State Department of Health used Little Mothers' Leagues in both rural and urban districts, and found it to be a very successful part of the campaign for the reduction of infant mortality.⁹⁶ By 1918, the New York State Departments of Education and Health were promoting a New York State Association of Little Mothers' Leagues.⁹⁷

Although Little Mothers' Leagues became widely popular, they began in the schools, and were primarily led by school nurses. The girls were to bring an actual baby to class, and the nurse taught them how to bathe, feed, change, and dress it. The priority of the classes was on proper feeding of babies. Lina Rogers thought if she could educate girls on proper nutrition and hydration, countering their "ignorance of the simple rules of hygiene and health," it would help lower the number of babies dying in the summers.⁹⁸ She also taught housekeeping skills such as making the bed, sewing buttons, washing and mending laundry, and washing dishes and bottles.⁹⁹

The focus on sterilization of bottles and cleanliness of milk made sense, since "little mothers" were not biological mothers, and therefore had to feed through artificial means. But, as Jacqueline Wolf pointed out when writing about Little Mothers' Clubs in Chicago, this might have sent the wrong message home to mothers. While visiting nurses were pushing breastfeeding as the safest and healthiest food, and that their babies' very lives may depend on using this

⁹⁴ Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, 71.

⁹⁵ Elizabeth Rennert, "Little Mothers' Leagues of New York State," *The American Journal of Nursing* 16, no. 4 (January 1, 1916): 306.

⁹⁶ *Ibid.*, 307.

⁹⁷ New York (State) Department of Health, *Outlines for Organizing and Directing "Little Mothers' Leagues."*

⁹⁸ Rogers Struthers, *The School Nurse*, 119.

⁹⁹ *Ibid.*

method, they were educating their daughters on bottle-feeding. Reformers knew the sway that American-born children had over their parents on the modern way to do things, but it might have been an unforeseen, and perhaps unavoidable, consequence that it would have appeared to mothers that bottles were a preferable, more scientific and clean, way of mothering.¹⁰⁰

Part of the point of these clubs was to make learning fun. Educators did not want to burden girls further, but instead to add enjoyment through socialization and teach them in a way that would give pleasure and relaxation.¹⁰¹ It was assumed that children were natural joiners who would like to belong to clubs. To give a sense of some of the topics that were covered in the classes and the way in which they presented to children, here is an excerpt from the *Outlines for Organizing and Directing 'Little Mothers' Leagues'*:

“Health Alphabet for ‘Little Mothers’”
A is for Adenoids which no child should own
B is for right Breathing to give the lungs tone
C is for Cough which we should not neglect
D is for Dentist who finds tooth defect
E is for Evils of foul air and dirt
F is for Fresh Air—too much cannot hurt
G is for Gardens where boys and girls play
H is for Hardiness gained in that way
I is for Infection from foul drinking cups
J is for Joy in the bubbling taps
K is for Knowledge of rules of good health
L is for Lungs whose soundness is wealth
M is for Milk, it must be quite pure
N is for Nurses your health to insure
O is for Oxygen not found in a crowd
P is for Pencils—in mouths not allowed
Q is for Quiet, which sick people need
R is for Rest, as part of our creed
T is for Tooth Brush used three times a day
U is for Useful health rules in the school

¹⁰⁰ Wolf, *Don't Kill Your Baby*, 21.

¹⁰¹ S. Josephine Baker, *Little Mothers' Leagues* (Albany, N.Y.: New York State Dept. of Health, Issued by Division of Maternity, Infancy and Child Hygiene, 1920s), 4.

V is for Value in learning these rules
W is for Worry, which always does hard
X is for 'Xcess, indulge in no form
Y is for Youth, the time to grow strong
Z is for Zest. Help the good work along.¹⁰²

Baker argued that girls should be trained for “intelligent motherhood.”¹⁰³ She harshly criticized an educational system that trained for every future profession except for the one that almost every child would grow up to do. Although Baker was not against the education of girls for professions—she was a doctor when few women were—she was against the lack of this additional training for life. Instead, preparation in the skills of motherhood only occurred during pregnancy or after birth, when they became urgently necessary. “There is hardly another situation in life where we follow such a course. Motherhood, instead of being a skilled profession is still an unskilled trade.”¹⁰⁴ She argued that childrearing was not instinctual. It must be taught. “Education for motherhood is as necessary as any other kind of education.”¹⁰⁵

So while these clubs helped to solve the immediate problems of the ill-cared for baby at home, girls were also targeted because of their own incipient maternity. The Little Mothers' Clubs also revealed anxiety about the constant state of pre-motherhood. In an age obsessed with the future of the race, and particularly of mothers' contributions to the success of the stock, the focus was on the ever-present possibility of motherhood. In this case it wasn't biological—protecting the reproductive capabilities of girls—this was a form of cultural pre-motherhood that meant that girls had to be trained early on in the proper methods of childrearing. As one nurse

¹⁰² New York (State) Department of Health, *Outlines for Organizing and Directing “Little Mothers’ Leagues,”* 15.

¹⁰³ Baker, *Little Mothers’ Leagues*.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid., 5.

wrote, “Every girl is a potential mother.”¹⁰⁶ Rogers concluded, “The training in these little mothers’ classes fits the girls for better work in school, better motherhood, and better citizenship.”¹⁰⁷

But despite this focus on maternity, very little attention was paid to sex. Within the newspaper articles about little mothers that I discussed above, the descriptions hint of the hidden sexual dangers of these pretty girls without supervision. Furthermore, these were children who acted above their age and were too adult-like in their responsibilities. Yet nowhere in Baker’s discussion of Little Mothers’ Clubs did sex education make an appearance. This was the one major difference between the school nurse handbook that Lina Rogers put together and the outlines for Little Mothers’ Clubs that were distributed by the New York State Department.¹⁰⁸ In Rogers’s manual for nurses, the last topic listed was: “Character talks—decency—sex education.”¹⁰⁹

Boys, too, were interested in the clubs, and, well, they got yard work.¹¹⁰ Many of those chores that boys were most likely already asked to do were considered their contribution to baby welfare, such as cleaning out the cellar and other outdoor tasks. It was emphasized to them that the sanitation and cleanliness of their homes was also important, and one nurse claimed that they were more happily willing to complete these jobs under this inflated mission. They were not, however, given any lessons in baby or home care; that lengthy syllabus was saved for the girls.

¹⁰⁶ Dorothy Rood, “Classes for Big and Little Mothers,” *The Public Health Nurse* 17, no. 9 (1925): 456.

¹⁰⁷ Rogers Struthers, *The School Nurse*, 128.

¹⁰⁸ New York (State) Department of Health, *Outlines for Organizing and Directing “Little Mothers’ Leagues”*; Rogers Struthers, *The School Nurse*.

¹⁰⁹ Rogers Struthers, *The School Nurse*, 124.

¹¹⁰ Rennert, “Little Mothers’ Leagues of New York State.”

The clubs also trained girls to become educators to their own mothers and to other mothers in the neighborhood. In an already-present reversal of the power dynamic of the immigrant parent with Americanized children, mothers were to be educated by their own daughters in the proper methods of mothering, just as they were the negotiators and translators in other arenas. The attention focused on the child in an immigrant community was not just about transforming the future, although that was certainly a part of it, but about the particular relationship between parent and child found in an immigrant community such as that in the East Side of New York City. There was often dependence of adults on their more Americanized, English-speaking children. Thus the children were not just the *future*, but were in fact the best educators for their own families in the present. The role reversal was most obvious in language skills, but with schooling, a whole new set of skills were piled on to that which children knew and parents did not. Although settlement workers sometimes found this role reversal disturbing, they also accepted the situation as it was and used it to their advantage.

Parents, teachers, and settlement workers all understood that immigrant children were more able to adapt to American ways than their parents, and indeed, many settlement workers feared that schools were doing too good a job of Americanizing children, at the risk of further alienating them from their mothers and fathers. Lillian Wald remarked on the “dependence of the elders upon the children” in the Lower East Side.¹¹¹ Reformers such as Sophonisba Breckenridge, Jane Addams, and Lillian Wald worked to preserve children’s respect for their parents by honoring the skills and cultural traditions that parents brought with them from their native countries.

But there was also a sense of worry that immigrant parents were not controlling their children. Jane Addams wrote of the reliance of immigrant parents on their children, lamenting,

¹¹¹ Wald, *The House on Henry Street*, 24.

“the most pathetic aspect of such cases is their revelation of the premature dependence of the older and wiser upon the young and foolish ...[which has] has given the children an undue sense of their own importance and a false security that they can take care of themselves.”¹¹²

Jane Addams also knew, however, that the education of the child, through the school, was the best way to educate parents and transform households. An immigrant child who learned cooking and sewing at school would “help her mother to connect the entire family with American food and household habits.” Girls could also educate their mothers on how to care for their own children:

...the girl who receives the first simple instruction in the care of little children—that skillful care which every tenement-house baby requires if he is to be pulled through his second summer ... Thus through civic instruction in the public schools, the Italian woman slowly became urbanized... and thus the habits of her entire family were modified. The public schools in the immigrant colonies deserve all the praise as Americanizing agencies which can be bestowed upon them.¹¹³

Rogers and Baker took advantage of this role reversal in immigrant families when they created Little Mothers’ Clubs. As part of the series of classes, girls were to do “personal service” for another baby, like “warning another mother” about pacifier use, or “instructing the mother” on how to keep milk clean. They could take another baby for a walk in the park “for air and sunlight,” which presumably would teach by example. Rogers wrote, “These girls love to pass on this information to their neighbors and many a ‘little mother’ leads a mother in Israel into the paths of tidiness and cleanliness.”¹¹⁴ They were also taught to look for signs of illness in other children and encourage their mothers to seek medical attention if necessary. Baker said they went off in directions they had not even considered. “These youngsters were among our most

¹¹² Jane Addams, *Twenty Years at Hull-House* (Signet Classics, 1999), 166–167.

¹¹³ *Ibid.*, 167.

¹¹⁴ Rogers Struthers, *The School Nurse*, 127.

efficient missionaries, canvassing tenements for us, cajoling mothers of their acquaintance into giving the baby health stations a trial, checking up on mothers who had backslid in attendance at the stations, telling every mother they met all about what they were learning.”¹¹⁵ In 1914, a *New York Times* journalist reporting on the Little Mothers’ Clubs in schools relished the admonishments that little girls gave to mothers regarding the proper care of their children. Some of these little mothers wrote in to tell what they had done as part of their instruction of mothers in the neighborhood. “One of them wrote to the league that she had reproved a woman who took a piece of candy from her mouth and gave it to her baby. Another told having taught a very young mother a lesson in sanitation.”¹¹⁶ Parents, teachers, and settlement workers all understood that immigrant children were more able to adapt to American ways than their parents, and school nurses took advantage of this parent-child dynamic when they formed Little Mothers’ Clubs.

While some historians have criticized of the Little Mothers’ Clubs and other in-home education methods for their Americanizing tendencies, historian Richard Meckel wrote that it would be a mistake to think that women rejected this kind of advice, and in fact, most welcomed it.¹¹⁷ He pointed out that Alice Hamilton, the Hull House doctor who investigated labor

¹¹⁵ Baker, *Fighting for Life*, 134.

¹¹⁶ “Little Mothers Get Points Today; Baby Welfare Campaigners Will Coach Them in the Public and Private Schools,” *The New York Times*, June 22, 1914.

¹¹⁷ Meckel, *Save the Babies*, 144–145; Mink, *The Wages of Motherhood*, 64–66. Historians have been particularly harsh on Little Mothers’ Clubs. They emerged around 1910 just as the Americanization movement was hitting its stride. Meckel showed that many of the studies on infant mortality categorized by race and ethnicity rather than socioeconomic class. Mink is a harsh critic of maternalist policy, and reveals its class and race dimensions, that although not based on racial exclusion (i.e. eugenics) instead focused their efforts on cultural uplift. “Besides encouraging mothers to conform to a class and culturally specific gender role, maternity policy addressed the choices made by mothers in the bearing and raising of children. Maternity policy favored medicalized, hospital births, asserted a partnership between women and (often male) physicians; assumed women needed to be trained for motherhood; and connected such training to the unlearning of cultural practices deemed unhealthful by reformers and physicians.” Mink

conditions in Illinois, found that most immigrant women did not take the methods wholesale, and instead adapted them to their own lives and cultures. At first this frustrated her, but by the time she published her memoir in 1943, she found this to have been “intelligent discretion.”¹¹⁸ In fact, she claimed, many of their practices would bear out as good science.¹¹⁹

The home visits by school nurses are an overlooked part of an important movement to include mothers in the new public health movement. School nurses had a powerful influence that reached well beyond a child’s immediate medical treatment, and became trusted representatives of the school within the homes of immigrant families by providing information that was both needed and desired by immigrant women who wanted to keep their children safe and healthy. They had exclusive access to both mothers and children; the school nurses were able to utilize the access they had to the child’s family and bring health and hygiene education to the entire community. Nurses did not simply transform the treatment of children in the schools—they transformed the school’s relationship to entire families and neighborhoods.

Lina Rogers described her role as a nurse as going well beyond the walls of the school building. “The nurse,” she wrote, “was interested in the child, the mother, the home, and she became the bond of friendship with the school.”¹²⁰ As nurses moved out of the private sphere of settlement houses, and moved into the municipalized realm of the schools, school nurses became important liaisons between the family and the state.

briefly discussed the role of Little Mothers’ Clubs as “emblematic of the maternalist preoccupation with maternal reform, which operated from the premise that the social mediation of mothers’ cultures, behaviors, and choices would enable poor, ethnic women and children to escape the effects of poverty. This strategy was the first step of maternalists’ war on poverty; it was also their ‘entering wedge for Americanization.’”

¹¹⁸ Meckel, *Save the Babies*, 137.

¹¹⁹ Alice Hamilton, M.D., *Exploring the Dangerous Trades: The Autobiography of Alice Hamilton, M.D.* (Boston: Little, Brown and Company, 1943), 69–70.

¹²⁰ Rogers Struthers, *The School Nurse*, 8.

A break from the norm:

The heterodox life of Dr. Sara Josephine Baker



Dr. Baker in 1922¹

Sara Josephine Baker was a doctor who figured prominently in the rise of school nursing. She began as a medical inspector in the New York City school district in 1901 before becoming Assistant Commissioner of Health in 1907, and she became the first woman to head a major unit when she became the chief of the city's Division of Child Hygiene in 1908. This was also the first such bureau in the United States, and would serve as the inspiration and model for similar agencies throughout the country.² During her term, Baker instituted innovative preventive health

¹ Underwood & Underwood, *S. Josephine Baker, M.D.*, Photograph, 1922, Images from the History of Medicine, Portrait no. 344.1, National Library of Medicine.

² Lillian D Wald, "S. Josephine Baker," *Survey* 48 (1922): 108. Lillian Wald wrote that by 1922, that 35 states had agencies devoted to children's health.

programs in the community and in the schools, and the infant mortality rate dropped dramatically. Baker was notable for being a doctor who began to see prevention rather than cure as a crucial aspect of public health, and who broke barriers in the medical profession by working to keep children well, rather than only treating them while sick.³

That was Baker's accomplished résumé; but Baker is also our least likeable character. She was boastful and self-promoting, and she took credit for the work of others, especially nurses. Her participation in some initiatives was so singularly focused as to be nearly blind to its personal impact. She identified too strongly with men and with the medical profession, and that inconveniences the narrative that I want to create about women and nursing. But yet I can't make her out to be the villain in my story. She was the link that it made it possible for preventive health to move from the world of nurses to that of doctors, from a feminine world to a masculine one, and bring community health to the municipality.

Sara Josephine Baker was born November 15, 1873 in Poughkeepsie, New York, home of Vassar College, into a prominent family with Quaker roots. Although a self-proclaimed tomboy who had always meant to "make up to [her father] for having been born a girl," Josephine was "thoroughly trained in the business of being a woman," and had expected to live life in a traditional manner. She did not revolt at the circumscribed world in which girls lived at the time. "I know that women of my generation who struck out on their own are supposed to have become rebellious because they felt cramped and suppressed and unhappy as children in an

³ S. Josephine Baker, *Fighting for Life*, Reprinted with historical introduction, Huntington, N.Y.: R. E. Krieger Pub. Co 1980 (New York: Macmillan Co., 1939); Wald, "S. Josephine Baker"; "Dr. Baker Is Dead; Health Expert, 71," *New York Times*, February 23, 1945; Richard A. Meckel, "Save the Babies": *American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*, The Henry E. Sigerist Series in the History of Medicine (Baltimore: Johns Hopkins University Press, 1990).



alien environment. It is a convenient formula and no doubt perfectly applicable in many cases. But it does not fit mine. I was reared in a thoroughly conventional tradition and took to it happily.”⁴

But perhaps Baker never had the chance to languish the way other women of her generation did, since she was not simply sent to college with no expectation of doing anything useful. Baker never planned to become a doctor; she had always intended to

enroll at Vassar. Her own mother had been in its first class, and although she didn’t finish, the rate at which faculty and students came by the house had given their family home the title of

Baker in 1894, just before entering medical college

“Vassar annex. But after a “series of calamities” unfolded in 1889, when she was sixteen and was preparing to

enroll, it was decided that it was in the best financial interests of the family for her to start on a profession. That year, her thirteen-year-old brother died, and then her father shortly thereafter, leaving the family in a less secure financial position. Therefore, Baker “considered [her]self to be elected” to become the family’s breadwinner. She decided that rather than spending the small amount the family could contribute to her education on a liberal arts college, she would instead attend medical school. Although her mother didn’t understand her decision, since there were still very few female physicians and it was considered “a harebrained and unwomanly scheme,” she contributed \$5000 of their diminishing funds for Josephine’s education.

After studying for a year to pass her exams for the New York State Board of Regents, in

⁴ Baker, *Fighting for Life*, 2.

1894 Baker enrolled at the Woman's Medical College of the New York Infirmary, founded by pioneer Dr. Elizabeth Blackwell and at that time run by her sister, Dr. Emily Blackwell.

Elizabeth Blackwell founded the institution when other medical schools in the United States refused to accept women, despite her belief that it would be preferable for existing programs to integrate and that women students would benefit from working with male instructors and peers.⁵

Emily Blackwell believed that women students would have to be better trained than their male cohorts in order to succeed, and she ran a rigorous program of study that weeded out nearly half of the 35 students who entered in Baker's year. Dr. William H. Welch, Dean of the Johns Hopkins School of Hygiene and Public Health, would later tell Baker that when he was on the committee that formed test questions for the Woman's Medical College, they were so difficult they would not have been "tolerated" at his own school. But Blackwell "was determined that all women graduated from her college should be a carefully selected group."⁶

Baker excelled, and in 1898 graduated second in her class; there was, however, one exception to her success. "Irony is certainly present in the fact that the one subject I failed in medical school was to be the foundation of my life work." The course was "The Normal Child" and the instructor Dr. Annie Sturges Daniel. "It was a subject far in advance of the time and Dr. Daniel had practically invented it herself, believing as she did that no doctor could be reasonably intelligent about normal children until he, or she, knew what the normal child might be like."⁷ Baker had no interest whatsoever in the course and "neither had anyone else as far as I could discover." This failure inspired Baker, and when she had to take the course again, she was

⁵ Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 67.

⁶ Baker, *Fighting for Life*, 34.

⁷ *Ibid.*, 42.

converted. Baker said that all those babies' lives that she was credited with saving were actually saved by Dr. Annie Sturges Daniel, to whom she dedicated her autobiography.⁸

After graduation, Baker interned at the New England Hospital for Women and Children in Boston along with classmate Dr. Florence Loughton, who, according to historian Judith Schwarz, was also her lover.⁹ Baker felt that her time in medical school was insulated from the real world, and when she had her internship in Boston and worked at the dispensary on Fayette Street in Boston, which was in the city's slums, she realized for the first time in her life that the "academic atmosphere is necessarily artificial."¹⁰ The Woman's Medical College at New York Infirmary did have an Out-Service department that served as a dispensary to the neighborhood poor, but students were not required to serve there during Baker's time.¹¹ So this indeed was the

⁸ Annie Sturges Daniel was a remarkable woman in her own right. She had graduated from the school a decade earlier, and then directed the Out-Practice department of the N.Y. Infirmary that served as a dispensary and did home visits to the neighborhood poor. The knowledge Daniel gained visiting the women and children of the poor radicalized her against the conditions in the tenements. She also fought for prison reform and against child labor in the garment industry. She also recognized the social conditions that brought medical problems. Her work gained her the title of "Angel of the East Side." "Dr. Annie S. Daniel 'Angel of East Side' Had Been at Infirmary for 60 Years," *The New York Times*, August 11, 1944; Morantz-Sanchez, *Sympathy and Science*, 171; Mary Elizabeth Perry, "Daniel, Annie Sturges (1858-1944), Health and Safety Reformers, Physicians," in *American National Biography Online* (Oxford: Oxford University Press, 2000); Consumers' League of New York City et al., ... *The Menace to the Home from Sweatshop and Tenement-Made Clothing: Testimony from Prominent Physicians, Nurses and Inspectors before the Tenement-House Commission of the State of New York*. (New York, 1901); Annie Sturges Daniel, *Report of Out-Practice of the New York Infirmary for Women and Children, 4 Livingston Place: 1853-1879, 1881-1891* (New York: Trow Directory, Print. and Bookbinding Co., 1891); "Doctoring the Poor for 35 Years; Dr. Annie S. Daniel Tells of Her Long Service on East Side," *The New York Times*, March 15, 1914.

⁹ Judith Schwarz, *Radical Feminists of Heterodoxy: Greenwich Village, 1912-1940*, Rev. ed. (Norwich Vt.: New Victoria Publishers, 1986).

¹⁰ Baker, *Fighting for Life*, 47.

¹¹ Morantz-Sanchez, *Sympathy and Science*, 171. It became a required part of the curriculum starting immediately afterwards in 1889.

first time that Baker was “really up against facts.”¹²

Baker published her autobiography in 1939, while Wald’s first Henry Street account was published in 1915, but one can’t help but recognize the parallel structures of their journeys into slum life; however, Baker was not nearly as sympathetic to the conditions of these inhabitants as Wald was to those on the East Side:

A man with a long beard brought the message. He silently guided me through snow-choked alleyways to an old frame house hidden in a court.... But I went on up the stairs, feeling with my feet for loose boards and holes in the enveloping darkness, and found my patient at last. I thought I already knew something about how filthy a tenement room could be. But this was something special, particularly in the amount of insect life.... All of it was the *n*th power of abject, discouraged squalor.¹³

Baker saw nothing noble about the people living within this environment, and expressed no belief in the fault of the society or forgiveness for its victims. “We were dealing with the dregs of Boston, ignorant, shiftless, settled irrevocably into surly degradation,” she wrote.¹⁴ This couple was not among the respectable poor, and made no attempts to make the best out of their miserable situation. Their tenement apartment was not clean and maintained; it had scraps of food strewn about and was riddled with roaches. And she added additional behavioral issues to the list of complaints. “Just to make sure they would be hopeless, many of them drank savagely. Having born children and lived and fought and made love regardless, they took that method of dodging the consequences.”¹⁵ She did show a tiny bit of lenience for their use of drink. “Nothing admirable about it, but one could not honestly blame them for making use of alcohol as an anaesthetic.”¹⁶ The woman’s injury was not brought on by childbirth, but by violence; her

¹² Baker, *Fighting for Life*, 47.

¹³ *Ibid.*, 49.

¹⁴ *Ibid.*, 48.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

husband had thrown a pot of scalding water on her. The tale ends with Baker being attacked by the drunken husband, and her pushing him down the stairs to save her own skin. The overall tone of this portion has more of a garish voyeurism than a sympathetic call.

She was not alone in finding slums to be terrifying, and her account was not unlike many of her generation of female doctors who interned at dispensaries. Others expressed horror at what they saw; some expressed amazement and gratitude for the sheltered lives they had led. But a number were self-absorbed and disappointed rather than moved. Anna Wessel Williams wrote about the East Side slums when working under Daniel in the Out-Service department. “The work was often thrilling, but mostly disappointing and depressing. Such a mass of dirty, irresponsible, non-responding people I met that I came to the conclusion that they were not ready for what we were able to give them. Crowded back tenements, dark broken stairs ... these and more were the impossible situations I was constantly meeting. How dissatisfied it all made me.”¹⁷

But although many other doctors privately shared their experiences at the time, Baker’s account was written long after, and one is not sure of the reasons for describing this particular incident; it certainly was not used to convince others of the necessity of action. Perhaps she just wanted to recount to the readers of her autobiography the most memorable details of her experience as a doctor; the tale certainly revealed her bravery and wit, since she was able to save her own life by outsmarting a drunken raging man, and it left no doubt that women doctors could face the world with as much competence as men. But it also lacked any pathos about life in the slums, and her journey brought no personal transformation at the end of its hallways. Whatever the case, this anecdote does not rouse sympathy or action, but merely disgust.

After their internship, Drs. Baker and Lughton set up a home and a practice New York

¹⁷ Morantz-Sanchez, *Sympathy and Science*, 172.

City and tried to earn a living. But it was a difficult time and place to practice medicine by any standards, which was made more difficult by their sex, and they barely scraped by during their first year. They were still limited to the model of many other working women who trail blazed their way into a profession: they used the fact that they were women to create a professional niche. Besides serving many of the women in their neighborhood, especially obstetrical cases, they came up with a proposal they pitched and sold to insurance companies to provide physical examinations for potential female clients. It was during this time of financial insecurity that Baker decided to take the Civil Service exam to become a medical inspector, and children became the mainstay of Baker's career.

Josephine Baker was an extraordinary woman, both in her time and today, who lived outside professional and sexual norms. She chose a profession that few women entered, and still fewer succeeded.¹⁸ Nursing was a traditionally female sphere, and in some ways, nurses capitalized on their femininity to develop new roles. But Baker went headlong into a field dominated by men and carried herself with a masculine authority.¹⁹ She went by the name "Jo" among her friends and dressed in tailored suits more like the dress of a man than that of the women of the age. She was happy to be seen as equal and indistinguishable from her male colleagues and was proud to recount a story in which one of them did not think of her as a woman.

Baker was a member of the Heterodoxy Club of Greenwich Village, where she met with other radical women of her time. Marie Jenney Howe founded the group in 1912, and added members by invitation until the time it disbanded around World War II, when many of the living

¹⁸ Morantz-Sanchez, *Sympathy and Science*.

¹⁹ Ibid. Morantz-Sanchez talks about this division in the earliest generations of medical doctors as well.

members were getting too infirm to continue with their every-other-Saturday luncheons. It is unclear when Baker joined the exclusive club, but she was certainly among the membership by 1920, if not long before. The Heterodoxy Club had many prestigious professional women as members, including Mabel Dodge, Crystal Eastman, Fannie Hurst, Elsie Clews Parsons, Charlotte Perkins Gilman, Elizabeth Gurley Flynn and Mary Ware Dennett. Many of them were career women who had a desire to be economically independent; many worked as writers or press agents, some were in the theater either as actresses or in another capacity. Some were lawyers, although not practicing law. And of course, Baker was a doctor. A good quarter of the women were lesbians; some were in open relationships, or had multiple partners, sometimes of both sexes. Some were married heterosexual women (while others were married to men while maintaining long-standing relationships with women). Many of the women were childless, while others had children.

Although the women varied in their professional and marital status, and many disagreed on politics, the one issue they agreed on was women's educational and sexual freedom. Florence Guy Woolston wrote a mock anthropological report on the members of the group, ribbing anthropologist Elsie Clews Parsons, in which she confirmed that they were open to all ideas. "The tribe of Heterodites is known as a tabooless group. There is the strongest taboo on taboo. Heterodites say that taboo is injurious to free development of the mind and spirit."²⁰

Baker and other members of the Heterodoxy Club were also aware of their importance in women's history, and she and her long-time partner, novelist Ida Wylie, among others, donated

²⁰ Florence Guy Woolston, "Marriage Customs and Taboos Among the Early Heterodites (1919)," in *Radical Feminists of Heterodoxy: Greenwich Village, 1912-1940*, ed. Judith Schwarz, Rev. ed. (Norwich Vt.: New Victoria Publishers, 1986), 107-109.

funds and provided their personal papers to create an archive.²¹ The effort failed to take off and the collections were returned to their donors during World War II. Inez Haynes Irwin's papers were eventually given to the Schlesinger Library, but Baker's manuscript for her autobiography has not been found.²²

Baker stood on the border between two worlds: one that was dominated by women and nurses, and the other by men and doctors. As a woman and doctor, she was able to act on the values of the public health nurses, even as she maintained the outlook of the medical profession. Baker and Wald had similarities in vision and in action, but their methods of bringing that forth were certainly very different. Wald used her stories to draw out the compassion of her readers: an innocent child, one that proclaimed purity and innocence to readers, led Wald into the slums; a man with a long beard, the least sympathetic of the victims of poverty, introduced Baker to the squalor. But Baker was no evil meanie; she represented a new type of woman professional who could act more on her own terms in official positions, rather than draw on storytelling and sympathy, to drive others to action; Wald remained in the philanthropic world that depended on donors who were sometimes motivated by tears and other times by facts. In the oldest of gender divisions, Baker did not have to depend on charm and coercion to get action like other disenfranchised women; she was in an official position.

²¹ Schwarz, *Radical Feminists of Heterodoxy*; Bert Hansen, "Public Careers and Private Sexuality: Some Gay and Lesbian Lives in the History of Medicine and Public Health," *American Journal of Public Health* 92, no. 1 (January 2002): 36. Hansen depended on Schwarz and Baker for his profile of Baker, but he does provide biographies of other gays and lesbians in the medical profession.

²² Schwarz, *Radical Feminists of Heterodoxy*, vii.

As a woman in a male-dominated field, Baker was able to coopt the values and programs of the female-dominated nursing profession and bring them into medical practice at the municipal level. Baker seemed to be taking credit for activities that were first inspired by nurses, and some of them by Lillian Wald, and her innovative programs emerged from the kind of preventive health activities that Henry Street nurses had been doing all along. But Baker was, in fact, uniquely situated to make preventive health more mainstream. In her own tribute to Baker, Lillian Wald congratulated the New York City Bureau of Child Hygiene under Baker's charge for its "intelligent use of the trained public health nurse."²³ Wald argued that with the creation of the bureau, there was a change in policy toward employing and utilizing nurses, "those unmatched field agents in the practice of preventive medicine." Wald argued that the school nurse "might be called the ancestor of the bureau," because for the first time, a municipal department acknowledged nursing as a legitimate use of public funds.²⁴ And Baker, too, recognized their value and expanded on it; Wald argued that this "was an important factor in extending the sphere of influence of the public health nurse under city control— the world over."²⁵ Nurses were the life force of public health, but Baker was their ally in implementing their efforts on a municipal scale.

²³ Wald, "S. Josephine Baker."

²⁴ Ibid.; Lillian D. Wald, *The House on Henry Street* (New York: H. Holt and Company, 1915), 53. She also argued this is *The House on Henry Street* when she wrote "The first nurse was placed on the city payroll in October, 1902, and this marked the beginning of an extraordinary development of the public control of the physical condition of children. Out of this innovation New York City's Bureau of Child Hygiene has grown."

²⁵ Wald, "S. Josephine Baker."

Chapter Four

From neighborhood to nation: Community health and the state

Progressive reformers, almost by definition, saw the need for greater regulations, and so urged government agencies to intervene by creating more rules and requirements to protect citizens. It seems natural that if reformers linked the problems facing people in the city to environmental and structural concerns, they would see their solution in structural transformation on the large scale: the state. But reformers saw a more magnanimous role for the civil government, a state that not only limited rights of others, but also provided greater services. School nurses tended to embody this dual role.

The public health movement demanded limits on individual behavior and required the enforcement of regulations by the state in order to be effective. In the nineteenth century, most of these regulations took the form of quarantine. After the Civil War, most public health officials devoted their major efforts to limiting the spread of infectious disease. The incipient version of the New York City Health Department, the Metropolitan Board of Health, gained some recognition for its containment of the Asiatic cholera outbreak in 1866-67. In 1870, New York City established a Department of Health as part of its new city charter, and very quickly worked to attack disease in the tenements through identification and isolation.¹

Over time, as they came to accept a modern scientific understanding of disease, health departments began moving away from quarantine and toward prevention and regulation.² Even though the Boards of Health were mostly advisory in their capacity, they wished to be granted

¹ John Duffy, *A History of Public Health in New York City, 1866-1966* (New York, Russell Sage Foundation, 1974), 51.

² John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990), 128.

more power to act and enforce regulations. The results of the very first survey of the American Public Health Association (APHA), founded in 1872, showed that many doctors in the field complained about the willingness of local governments, who feared their expanding authority, to allow boards of health any control. As Dr. John M. Toner wrote, the courts were reluctant to support health laws “lest they seem to abridge the rights of property and individual freedom.”³ Even so, the APHA carried on, and over time, made efforts toward structural changes in cities, such as sewage and garbage disposal, and the ventilation of tenements and public buildings.

It should be no surprise that anyone working for the Department of Health thought it was counter to the goals of public health to hold individual rights as sacrosanct. The Progressive-era belief that certain liberties had to be checked to protect the greater good was especially true in the arena of health and disease. Each new regulation created to protect the greater good, in this case, the health of the community at large, meant that some individual liberty was being checked. Quarantine, although more effective than any other method available to stop the spread of a contagious and deadly disease like cholera, necessarily limited the freedom of movement of certain individuals; compulsory vaccination, although proven to be effective in preventing an outbreak of a pandemic, challenged the rights of individuals over their own bodies in order to limit the risk of exposure for others.⁴

³ Ibid., 131.

⁴ Robert D. Johnston, *The Radical Middle Class: Populist Democracy and the Question of Capitalism in Progressive Era Portland, Oregon*, Politics and Society in Twentieth-Century America (Princeton, N.J: Princeton University Press, 2003). In some cases, this might even mean sacrificing your own child in order to protect the children of others. Although there are certainly anti-vaccination crusaders in the present day who claim that vaccinations are too dangerous to risk, when vaccination efforts were first made, the odds were far worse. Robert Johnston demonstrated with his protagonist Lora Little that indeed the risk of death from the vaccine was higher than the risk of contracting the disease. The high risk of death from the smallpox vaccine, and later the risk of becoming paralyzed from the live polio vaccine, meant that sometimes you would have to risk the health of your own child for the health of the herd.

The case of Typhoid Mary, whom historian Judith Leavitt called “captive to the public’s health,” really brought home the intrusion on individual rights that public health actions required.⁵ Mary Mallon, a healthy carrier of typhoid, was never convinced of the germ theory, and was imprisoned for the rest of her life when she refused to stop working as a cook. In August of 1906, a typhoid outbreak sickened six out of eleven members of a family on vacation on Oyster Bay, Long Island. The owner of the home hired civil engineer George Soper to find the cause, lest the house become unrentable owing to association with disease. Soper traced the disease to the Irish-born cook who had already left the premises. With further research on her job history, he discovered that typhoid had struck seven out of the eight households in which she had worked. Soper tracked her down in a Park Avenue home where she was again employed in the kitchen, showed up at the door unannounced, and accused her of spreading disease. Mallon, who felt perfectly healthy, ejected him from the house. But Soper was unrelenting. He contacted Herman Biggs of the New York City Health Department, and convinced him that she was carrying disease and that he should find her and collect samples of blood and urine.

Biggs sent out our very own S. Josephine Baker, who was then working for the health department as Assistant to the Commissioner of Health, to complete the task. Dr. Baker gave her job description at the time as a “trouble shooter.” She was sent on those cases “which did not fit into the assignments of the regular staff of inspectors.”⁶ And her job often required the assistance of policemen. She would enter flophouses in the middle of the night to deliver smallpox

⁵ Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public’s Health* (Boston: Beacon Press, 1996).

⁶ S. Josephine Baker, *Fighting for Life*, Reprinted with historical introduction, Huntington, N.Y.: R. E. Krieger Pub. Com 1980 (New York: Macmillan Co., 1939), 67.

vaccinations with these enforcers by her side. “There can hardly be an obscure corner of Manhattan Island into which I have not poked my official nose at one time or another.”⁷

According to Baker, she was given no warning that Mallon might be uncooperative. When Mallon showed up again at the Park Avenue brownstone, Baker perceived her to be a “clean, neat, obviously self-respecting Irishwoman.” But when Baker requested the specimens, Mallon offered a resolute no. Here is the way Baker understood this interaction: “Obviously here was another case of that blind, panicky distrust of doctors and all their works which crops up so often among the uneducated—and among the educated too, for that matter.”⁸

Baker showed up at 7:30 the following morning, March 20, 1907, backed by three policemen and an ambulance. Mallon was prepared for the onslaught, and met Baker at the door with a “long kitchen fork in her hand like a rapier.” She lunged at Baker, and before Baker could recover herself, Mallon had disappeared, and hid herself with the aid of neighbors for several hours. When at last she was found, she still did not give in easily, and had to be transported to the hospital to be admitted in order to obtain the specimens. At that point, Baker had the aid of five policemen, and she literally sat on Mallon in the ambulance on the way to the hospital to keep her from escaping. Baker said, “By that time she was convinced that the law was wantonly persecuting her, when she had done nothing wrong.”⁹

As a healthy carrier, Mary Mallon had been exposed to the bacteria that causes typhoid, but never showed symptoms herself. She could therefore transmit the disease without feeling sick. Mary Mallon claimed she had never been ill, and refused to believe that she could be responsible for the illness of others. The samples that were collected revealed that she did have

⁷ Ibid., 69.

⁸ Ibid., 73–74.

⁹ Ibid., 75.

the bacteria in her system. Since she refused the treatment the doctors offered her (which was to remove her gall bladder), the Department claimed they had no choice but to keep her away from other people. Baker continued to blame Mary Mallon for her own incarceration. “And, to me, the interesting part of it all was that if Mary had let me have the specimens I was sent to get, she might have been a free woman all her life. It was her own bad behavior that inevitably led to her doom. The hospital authorities treated her as kindly as possible, but she never learned to listen to reason.” Many other healthy carriers were eventually discovered who were permitted to live freely, but as Baker wrote, “It was Mary’s tragedy that she could not trust us.”¹⁰

Baker, like many others, ignored the dimensions of race and class that encouraged this distrust, factors that may have impelled Mallon to continue working as a cook despite her best interests. This account of her encounter with Typhoid Mary, the Irish cook, is narrated in the chapter immediately following her telling of her summer working in the slums of Hell’s Kitchen, where she gives the reader a rather insensitive rundown of the cultural failings of the Irish, who were “incredibly shiftless, altogether charming in their abject helplessness, wholly lacking in any ambition and dirty to an unbelievable degree.” Working for the Health Department, she “climbed stair after stair, met drunk after drunk, filthy mother after filthy mother and dying baby after dying baby.”¹¹ She also described the mothers as “lackadaisical” and “fatalistic” and sketched multiple scenes of drunken Irish mothers and fathers. There is no transformative moment for Dr. Baker, no “baptism of fire.” In fact, she wrote, “Why I stayed on that job is another mystery.... Perhaps the sight of such sluggish, crawling misery fascinated me. You could not say that I was sentimental about these people. I had a sincere conviction that they would all be better off dead

¹⁰ Ibid.

¹¹ Ibid., 58.

than alive. But they apparently had an instinct for life and I had to go through the motions of helping them.”¹²

I can only imagine that this contempt for the Irish played in to the way Baker treated Mary Mallon at their first encounter, and that Mary Mallon had already felt this disdain in previous interactions with others like Baker. Immigrants were accustomed to being associated with filth and disease, and Mallon was probably particularly rankled by the accusation that she was spreading typhoid when she felt just fine.

Furthermore, the Health Department, George Soper, and Josephine Baker all seemed to disregard the social status that cooks had within the hierarchy of household help. Mallon was detained on North Brother Island for three years, and was released when she promised the Health Commissioner that she wouldn't handle food any further. “But cooking was, after all, her trade and she was constitutionally incapable of believing all this mystery about germs,” Baker wrote. Soper even impugned cooks as a group, remarking on their uncleanness.¹³ Those upstairs might have disparaged the work of the cook, but those downstairs knew that hers was a good position. When Mallon was offered a job as a laundress at the time of her release, it was an unacceptable demotion. When she was caught in the wake of yet another typhoid outbreak, she was imprisoned for the rest of her life, dying at North Brother Island in 1938.

The case of Typhoid Mary convinced Dr. Baker, and probably many others, of the strength and reach of the Health Department. “Typhoid Mary made me realize for the first time what sweeping powers are vested in Public Health authorities. There is very little that a Board of Health cannot do in the way of interfering with personal and property rights for the protection of

¹² Ibid., 59.

¹³ Ibid., 84.

the public health. Boards of Health have judicial, legislative and executive powers. They are the only public agencies that combine all of these powers.”¹⁴

But there was another state agency that was growing in power during the Progressive Era—the school. By 1918, compulsory education laws were passed in all states, requiring children to be in school at least until the age of 14, with 31 states keeping children in school until 16.¹⁵ New York passed its compulsory education law in 1874, and although the legality of national compulsory education laws would be tested in courts, state regulations remained on the books.¹⁶ The 1874 law said that children between the ages of 8 and 14 had to attend school for 14 weeks out of the year, eight of them consecutively, which is only half of the twenty eight weeks that schools were generally in session. The penalties for not abiding by the law were financial, with fines for the parents increasing over time, starting at \$1 for the first week and \$5 in following weeks, with a maximum of \$66 per year. Employers were also included in this law, which stipulated that “no person or company” should employ children between eight and fourteen “in any business whatever” during the school hours of the district, unless they had already completed the required number of weeks of schooling, in which case they should have a certificate from the teacher. Employers would be fined \$50 for each child labor violation. The school districts were responsible for preventing “juvenile vagrancy,” and needed to come up with solutions to enforce this law. “The average period of instruction at the public schools is twenty-eight weeks annually,” reported the *New York Times* in 1874. “This law requires these children to receive for

¹⁴ Ibid., 77.

¹⁵ David Macleod, *The Age of the Child: Children in America, 1890-1912*, Twayne’s History of American Childhood Series (New York: Twayne, 1998), 75.

¹⁶ Eleanor Brownson Taylor, *Children’s Progress, 1833-1933* (Washington, D.C: The Children’s Bureau, U.S. Department of Labor, 1933).

six years only one-half the schooling the State provides for them. Even if vigorously enforced it secures them barely enough education to become good citizens and useful members of society; hence the greater necessity for perfect enforcement.”¹⁷

Even so, it was clear that compulsory education laws were barely being enforced throughout the 1880s and 1890s.¹⁸ One of the main reasons for this was that there were quite simply not enough seats for eligible children, and adding the “vagrants” to the school rolls would only compound the problem. Sometimes it was an issue of city organization and communication between local and central boards—schools sat empty while uptown schools were above capacity. Once some of the downtown boards shifted their attention to uptown construction, the downtown schools were overflowing with immigrants. But mostly the construction of schools fell behind the surge of population growth. In fact, not only were schools not seeking out truant students; they were turning away eager students for want of space.

New York City schools began to increase their enforcement for truancy in 1901, after a successful reorganization of the school board which centralized and professionalized the school system. The *Third Annual Report of the City Superintendent of Schools* shows that truant officers were much more active in the year 1900-1901 than they had been the previous school year. “Apparently, either truancy was much more rife throughout the city during the school year... or else the attendance officers were much more energetic.” Numbers went up across the board; more than 30 percent more cases were investigated, the number of parents or guardians arrested

¹⁷ “Compulsory Education. The Law on the Subject. What It Requires and How to Do It,” *New York Times*, September 26, 1874.

¹⁸ Diane Ravitch, *Great School Wars, New York City, 1805-1973: A History of the Public Schools as Battlefield of Social Change* (New York: Basic Books, 1974), 112.

for violation more than doubled. They found more under-aged children working, and placed more children in schools than in the previous year.¹⁹

School districts granted work permits to children who had reached the appropriate age and level of schooling. Although these work permits were often false or forged, it was one way for schools to attempt to keep children in attendance for as long as possible. Eventually the task of giving out work permits was put in the hands of the Division of Child Hygiene when it was reorganized under the Department of Health in 1908.²⁰

Through increased enforcement of truancy and child labor laws, schools, too, were imposing their reach and authority on individuals and families. Necessarily, once the school started taking more responsibility in the lives of children, there was a threat to parents' own sense of authority. Rogers and Baker, in particular, had to justify their involvement in children's lives as agents of the state in ways that Wald never felt necessary in her role as a settlement house worker. These two interventions and institutions—public health and public school—were powerfully combined in the person of the school nurse.

In the very first line of the very first chapter of *The School Nurse*, published in 1917, Lina Rogers wrote: “Much has been said about interference with personal liberty in connection with compulsory medical inspection of schools. The same question was violently argued when

¹⁹ Department of Education The City of New York, *Third Annual Report of the City Superintendent of Schools to the Board of Education for the Year Ending July 31, 1901*, n.d., 60, Micro. Cab. Roll 14, New York, City Hall Library.

²⁰ S. Josephine Baker, *The Bureau of Child Hygiene of the Department of Health of the City of New York*, Monograph Series / Department of Health of the City of New York; No. 4; (New York: Dept. of Health of the City of New York, 1915), 147–157; C.-E. A. Winslow, *The Life of Herman M. Biggs* (Philadelphia: Lea & Febiger, 1929), 215. Before this new division was created, employment certificates had been distributed through the Division of Sanitary Inspection, just as many other child-related enforcement tasks were dispersed through various city departments until this division was created to consolidate the affairs of children in the city.

compulsory education was introduced. Why should the State control education and enforce attendance at school? This is a reasonable question, and it is also reasonable to ask why the State should step into the school and ask about a child's physical condition."²¹

It is clear that for Rogers the issues of personal liberty and the role of the state in the lives of children were of utmost priority. She answered the concern about state intervention immediately. "Society for its own well-being must impose obligations upon its members. If the exercise of the individual's liberty or right, or the individual's idea of right and liberty, inflicts injuries upon the people as a whole, then the individual liberty must be curtailed or prohibited. All 'law' is but restriction of individual liberty or action, so that people may live amicable in a community without danger to each other. The first aim of every law is for community or State protection."²²

The way she addressed the issue of compulsory education as a parallel issue is important, because Rogers saw the role of the state in the realms of health and education as combined. She argued that both compulsory education and medical inspection were crucial for the future of the child. But in some ways, she implied that any debate over compulsory education was moot, that most people had come to accept this particular intervention of schooling in the lives of children, and that they would soon say the same regarding the physical care of children within the schools. "No one will now deny that education of the young is a supreme necessity! Is it not of even greater importance that every child has a sound constitution and obtains full physical development!"²³

²¹ Lina Rogers Struthers, *School Nurse; a Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease Among School Children* (New York and London: G.P. Putnam and Sons, 1917), 1.

²² Ibid.

²³ Ibid., 2.

Rogers wavered on this issue of state authority. At first, she made a strong claim that indeed state intervention was necessary for both the success of the individual child and for the nation as a whole. But she also softened this position with the tone and rhetoric of cooperation among all parties. “How can this health education be given with the least disturbance of the home and school! [sic] This can only be done by the most cordial cooperation between the parents and school workers, by more intimate relations between home and school, by parental knowledge of the aims of the school, by home sympathy with the school home.”²⁴

The main reason that Rogers felt that the school needed to take over the care of the physical health of children was that parents had failed to do so adequately themselves. She discussed the way that Romans had relegated both the physical and educational development of children to the State rather than to the parents. “With them, however, the child was first the child of the State, and secondly the child of his parents...”²⁵ It is unclear what the implication of this is supposed to be in the United States, and to whom she thought the child belonged to first. But she did seem to say that parents now had primary ownership of their children, and that this had left certain aspects of their development to worsen. More importantly, she argued that the combined forces of environment and lack of state concern for the physical well being of children had deleterious consequences. And in fact Rogers also argued that these aspects of a child’s life should not have been left to parents, because parents, for whatever reasons, were failing to maintain the health of children.

This emphasis on the power of the state was a more recent development in Rogers’ writings. In her earlier writings, Rogers did not make any mention of “the State” as she did in the 1917 introduction to the nursing manual. Her very first articles were far more factual, filled with

²⁴ Ibid., 4.

²⁵ Ibid., 5.

information rather than opinions, but as time went on she became more expressive of her own views.²⁶ She may just have come into her own as a writer and expert on the subject of school nursing, rather than simply a disciple of Lillian Wald. Indeed, in 1902, it was Wald, who presented the first conference paper on school nurses and then printed it in the *American Journal of Nursing*; it served almost as a letter of introduction, and included a copy of Rogers' own report.²⁷ Wald continued to write articles on school medical inspection as well, so she did not merely turn over the project.²⁸ But most of Rogers' early articles were designed to educate nurses in other cities on how to set up a school nurse program. Indeed, these articles were mere reports about the activities of the nurse and the very recent history of this momentous addition to the New York City municipal payroll. Her continued emphasis was on the necessity of keeping children in school to learn, not on the importance of school as an arm of the state. She did, however, make the link between the school and health, and school as the site to administer such care to maintain the physical bodies so that students might learn better.²⁹ But by 1917, and the onset of WWI, "the State" took on a more potent meaning, with the health of future soldiers becoming a part of the accepted rhetoric, and Rogers used that to her advantage.

Although Rogers advocated for a greater role of the state in the lives of children, she did not believe that the school nurse herself should be the one to perform the many tasks that were being executed by other agencies, private and public. Furthermore, even as state agencies were

²⁶ Lina L. Rogers, "Some Phases of School Nursing," *The American Journal of Nursing* 8, no. 12 (September 1908): 966–74; Lina L. Rogers, "The Nurse in the Public School," *American Journal of Nursing*, August 1905.

²⁷ Lillian D. Wald, "The School Nurse in New York City, in Official Reports of Societies," *The American Journal of Nursing* 3, no. 3 (December 1902): 221–22.

²⁸ Lillian D. Wald, "Medical Inspection of Public Schools," *Annals of the American Academy of Political and Social Science* 25 (March 1905): 88–96.

²⁹ Lina L. Rogers, "School Nursing in New York City," *The American Journal of Nursing* 3, no. 6 (March 1903): 448–50; Lina Rogers, "A Year's Work for the Children in New York Schools," *The American Journal of Nursing* 4, no. 3 (December 1903): 181–84.

beginning to take over many of the programs that settlement houses initiated, settlement house workers did not envision that their own roles would disappear. In 1905, sociologist and future anthropologist Elsie Clews Parsons wrote an article for the philanthropic journal the *Charities and the Commons* advocating that the role of the school nurse “be enlarged” to tackle basically all of the social problems facing children in New York, including child neglect, education for motherhood, and infant mortality.³⁰ Parsons’ article was a bit sloppy and lacked a coherent message, and it is doubtful that she consulted with Rogers before she wrote the article, although she had some incomplete knowledge of the development of the program.³¹

Parsons’ article started with a study she was reading on the case of England; she made a comparison between the conditions in the slums of London and New York, and suggested that some of the solutions proposed in this English report would serve just as well in the United States. One of these was to make the school nurse “the state’s most indispensable agent in keeping down its budget” for all of the agencies that dealt with children in their neglect, illness, or criminality. The school nurse should be in charge of children even before they hit school age. “To fulfil [sic] its educational purpose therefore, education for citizenship, the state must begin its work of education at birth.” Parsons also argued that the local school board should do more to care for the children of the city. She shared the vision of many when she said that the schools should become “neighborhood centers” that would take over much of the work that settlement house workers were doing.

³⁰ Elsie Clews Parsons, “The School Child, the School Nurse and the Local School Board,” *The Survey (Charities)* 14, no. 26 (September 23, 1905): 1097–1104.

³¹ It also ended with a rather upsetting eugenic suggestion that girls who have passed “continuation” classes in training for motherhood, such as cooking and household care, should receive a certificate to be placed in a dossier along with family history of health and character in order to get a marriage license.

Rogers and other settlement house workers may not have disagreed so much with the article's content as perhaps with its presentation. In fact, many of the "ideas" that Parsons presented had already been proposed or established, and she denigrated the work settlement house workers were already doing, calling it "makeshift" and "temporary." She argued that all of their activities should be turned over to schools. "I believe that, thanks largely to the settlements themselves, the time has come for them to entrust many of the tasks which they have been undertaking for the past ten years in New York city [sic] to the school organization of their neighborhood."³²

Although many could agree that the schools should do more in the lives of children, disparaging the work of settlement houses was not a way to win supporters. I can imagine that there was a discussion around the Henry Street breakfast table about how to respond to this paper and how to divvy up the issues that each should confront. Lina Rogers and Florence Kelley each wrote a letter in response to the article, along with some other settlement and charity workers.³³ Kelley took issue with the division of the school board and the settlement house into two discrete camps, while Rogers protected the realm and professional status of nurses. James Hamilton, head of neighboring University Settlement, discussed the ways in which the settlement house could have a permanent role in the community, even after transferring many activities to the state realm.³⁴

Hamilton agreed with many of Parsons' fundamental arguments about the role the school should play in the community, and indeed pointed out that the settlement houses had done just

³² Parsons, "The School Child, the School Nurse and the Local School Board," 1103.

³³ Lina Rogers et al., "The Settlement Worker, the School Teacher, the Nurse and Others: Communications to Charities from Readers of Mrs. Parson's Article of September 23," *The Survey (Charities)* 15, no. 2 (October 14, 1905): 102–7.

³⁴ Ibid.

what she suggested. “The idea of making the local school board responsible for the culture needs of the neighborhood beyond the ordinary curriculum needs of the schools is admirable. The idea of settlements transferring their functions to the school or to any other social agency, when the interest of the neighborhood seems to demand it, appears to be entirely sound, and as the author says, it has largely been carried out in practice.”³⁵ Where Hamilton took issue was with the statement that the settlement houses were “makeshift” and “exotic.” He imagined what would happen if eventually many of the activities of the settlement could be transferred over to other institutions, but he still believed that the settlement would have a lasting purpose “in the function of studying the neighborhood’s social needs of every character.”³⁶ “There seems to be a place, and a permanent one, for a center where citizens can come to consider where they can best throw their efforts to promote the social welfare.” State institutions could become too entrenched, while the social center could offer a disinterested perspective that might have more influence. As such, settlement houses could “serve the institution in ways in which they find it difficult to serve themselves.” Another important feature of the settlement house, Hamilton argued, was the very fact that it was outside the state institutions, and therefore could “move in advance of an existing organ of government—perhaps to create a model for it.”³⁷

Florence Kelley rightly pointed out that settlement houses and school boards were not mutually exclusive.³⁸ In fact, settlement residents had long played an active part in government, particularly on school boards. Within months of opening, Toynbee Hall residents served on school boards in London, and Jane Addams of Hull House was at the time chair of a committee on the Chicago Board of Education. “To serve on a public body, state, county or local has been

³⁵ Ibid., 102.

³⁶ Ibid.

³⁷ Ibid., 103.

³⁸ Ibid., 104–105.

the ever-recurring task of the residents of Hull House.” Jane Addams, Julia Lathrop, and others, served as everything from local postmaster to inspector of alleys to state investigators. She did not mention herself, but Kelley worked for the Illinois Bureau of Labor Statistics as a special agent to study women workers and the sweatshop system, and was then given the job as the chief factory inspector in the state. And Kelley certainly pointed out the various residents of the nursing settlement and their active participation in state agencies. Here she mentioned that Lillian Wald was on one of the mayor’s commissions, and that Lina Rogers was employed as the superintendent of school nurses. Three other Henry Street residents were in fact on the school board. The distinction between public and private agencies was never so clear cut as Parsons imagined.

Rogers responded by clearly stating what it is that school nurses were already doing for the city, since Parsons didn’t seem to have a clear idea of what their role was. Rogers wrote about the routine inspections, the frequent home visiting, as well as how the nurses were employed during the summer vacation to help new mothers care for their babies. But she did not feel that the nurses should take on any additional responsibilities that would leave school nurses overburdened and unable to focus on their primary job—taking care of school age children. Although Rogers granted that mothers and babies also needed attention, and that more nurses should be added to that realm of activity, their care should not be the responsibility of school nurses. The United States did not have a district nursing system like England’s, and so it was left to volunteer agencies, such as the Henry Street Visiting Nurse Service, to do the variety of work that Parsons now insisted school nurses should do. Implicit in Rogers’ letter was a desire to protect the professional status of nurses and to keep the work of school nurses from being overly generalized. Rogers agreed that all of the work that Parsons suggested should be done in

neighborhoods, but “it is not the public school nurse who should be engaged in them.”³⁹ It would both overwork the school nurses and distract them from their important task to be taken away and used as tuberculosis nurses or as well baby visitors.

Rogers was thus defining the realm and roles of the school nurse and protecting the professional status of visiting nurses as specialists. One of the ways that Parsons irked Rogers was to suggest that school nurses might need less education, or at least a different kind of education, that focused more on the aspect of the work that we would now call social work, even at the expense of the medical portion of the education. This was not a way to win the favor of professional nurses, especially visiting nurses and school nurses, who advocated for more training and certification rather than less. Rogers asked if anyone would request doctors to sacrifice their special training to work as truant officers or settlement residents. “Yet rightly understood the time and strength and skill of the public school nurse should be as closely devoted to her task as the physician’s to his own.”⁴⁰ She emphasized that she too had years of education and training, which should be used in the arena in which she was the best prepared and most needed. “It would be an uneconomic application of nurses who have spent years in acquiring rigorous professional training to distract their attention from the school children and place them at the disposal of volunteer neighborhood agencies for miscellaneous work.”⁴¹

Parsons was recommending a very powerful role for the school nurse as a state agent who could perform many tasks in the neighborhood, a notion which Rogers could have embraced wholeheartedly as a means to expand her own professional role. But Rogers did not want to dilute her status as an expert. Even if the nurses of the settlement did think that the state needed

³⁹ Ibid., 107.

⁴⁰ Ibid.

⁴¹ Ibid.

to take over a greater portion of the responsibility of caring for mothers and babies, to diminish their own expertise by being demoted to teachers or social workers was not in their best professional interest. Indeed, it would have put the future role of the various specializations of public health nurses at risk just as nurses were beginning to organize themselves professionally.

These responses from settlement house residents reveal that even though they wanted greater government involvement, settlement house workers still envisioned a permanent role for the settlement house as a place of innovation and a source of unbiased study and critique of the existing organs of government. The way Hamilton discussed state institutions showed that he shared the belief that government was always sluggish when it came to change, and needed the prodding of private agencies. Kelley's letter showed that the overlap between settlement houses and state agencies was very great, and that indeed many settlement workers had dual roles. Finally, Rogers's letter showed the limits of what she felt the reach of the school nurse should be as a state agent, and a desire to keep the school nurse's realm very closely tied to school children.

Some historians have been overly critical of reformers and health educators in the public schools. Stephan F. Brumberg, for example, has emphasized just how all-encompassing the Americanization project was for immigrant children in the Lower East Side, with schools that attempted to obliterate any cultural heritage that immigrants might carry with them.⁴² He is among those historians who see reform in the schools as a form of social control meant to ease fears about hordes of immigrants and maintain stability in the face of great cultural change. Alan

⁴² Stephan F. Brumberg, "The One-Way Window: Public Schools on the Lower East Side in the Early Twentieth Century," in *Remembering the Lower East Side: American Jewish Reflections*, ed. Hasia R Diner, Jeffrey Shandler, and Beth S Wenger (Bloomington: Indiana University Press, 2000).

Kraut has been more measured in his view of the social control thesis, but still argued that the teaching of health and hygiene was part of a broader Americanizing project taking place in the schools.⁴³

Although Americanization was certainly a part of the experience of every school child, many of the reformers spoke about school and health in terms of both individual rights and social welfare, rather than about the fears of the unassimilated mob. Reformers, nurses, and educators believed that children had the right to play, the right to school, and the right to health, and wanted to expand those rights rather than limit them. The school was not only the place to instill civic values for the purpose of social control and patriotic loyalty, but also a place in which the rights of each student could be expanded and acted upon.

As reported in the philanthropic magazine *Charities* in 1901, Julia Richman, then principal of Public School No. 77, suggested that “circulars should be prepared by some society, explaining *their rights* to parents and telling them where to go and who to go to secure what is due their children.”⁴⁴ Photographer and journalist Jacob Riis agreed that a child’s “right to play” was “fundamental.” Some of the concomitant language did express fear about the future of the United States and the possibility of the rise of criminality. There was the implicit argument that if communities do not pay attention to children, other broader risks to democracy will emerge. The objective of this argument was not to suppress that child, but to argue for greater rights: “Upon the preservation of the child’s right to play depends more than we have as yet made out. It is but a poor preparation for the exercise of his rights of citizenship to deprive him of his own

⁴³ Alan M. Kraut, “‘East Side Parents Storm the Schools’: Public Schools and Public Health,” in *Silent Travelers: Germs, Genes, and the “Immigrant Menace”* (New York: Basic Books, 1994).

⁴⁴ Josephine Shaw Lowell, “What Can Parents Do To Help School Teachers,” *Charities* VI, no. 20 (May 18, 1901): 432–35.

natural rights. We marvel at the young roughs not respecting our rights, though we never give them any.”⁴⁵

Libraries, school playgrounds, study halls, kindergartens and other projects began in the settlement house and eventually found their way into schools. Not only did these specific projects enter, but underlying these projects was a growing concern for the whole child with needs outside of the traditional structure of the classroom. Motivated by settlement house workers and other reformers, schools began to create extended day programs, classes in vocational education, and in general, a curriculum that more closely matched the needs of immigrant children who were likely to enter the workforce.

Wald remarked on the physical proximity of the settlement to many local schoolhouses, and noted: “It is not unnatural, therefore, that the school should loom large in our consciousness of the life of the child.” But the school did not only “loom large” geographically; Wald realized that it was an important force in children’s lives more generally. Wald never saw the settlement house as the foremost institution in a child’s life, no matter what kinds of services it could offer. The school and the home were the primary spaces in a child’s life, with the settlement house as a highlight. “The settlement at no time would, even if it could, usurp the place of the school or home. It seeks to work with both or to supplement either.” Despite the fact that Wald wanted the school to add these services to the municipal budget, she did not think that the settlement house would outlive its own role. Although the school played a large part in the lives of children, and she wanted that role to be even larger, she still saw the settlement house as a seedbed for future projects. As an institution, a “rigid system,” the school district could never be as innovative as the settlement houses, because the settlement houses had room for experimentation. They were

⁴⁵ Riis, Jacob A., “The Rights of Children,” *Charities* VII, no. 2 (July 13, 1901): 48.

not “committed to any fixed programme” and could adapt quickly, change course, and come up with new solutions, and “the results of these experiments...affected school methods,” wrote Wald.⁴⁶

Settlement house programs were moving into schools, and the creation of the New York Bureau of Child Hygiene under the direction of S. Josephine Baker was an even bigger step toward creating state responsibility for the health of children. But by far the greatest accomplishment of child health advocates was the creation of the Federal Children’s Bureau, signed into law on April 8, 1912 with a former Hull House resident at its head.⁴⁷ It was placed in the Department of Commerce and Labor and had a very small appropriation and a minuscule staff of just 15, most of whom were women. According to historian Molly Ladd-Taylor, this small allotment compared to other agencies meant that Congress had meant for it to be “merely symbolic.”⁴⁸ But with the powerful leadership of its first director, Julia Lathrop, the agency would have a broad impact.

In 1932, Wald told her audience that the Children’s Bureau touched more lives personally than any other government agency. She said that the Bureau was for all children, rich and poor

⁴⁶ Lillian D. Wald, *The House on Henry Street* (New York: H. Holt and Company, 1915), 105–106.

⁴⁷ Kriste Lindenmeyer, *A Right to Childhood: The U.S. Children’s Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997); Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana, Ill.: University of Illinois Press, 1994); Molly Ladd-Taylor, “Hull House Goes to Washington,” in *Gender, Class, Race, and Reform in the Progressive Era*, ed. Noralee Frankel and Nancy S. Dye (Lexington, Ky: University Press of Kentucky, 1991), 110–26; Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers’ Letters to the Children’s Bureau* (New Brunswick and London: Rutgers University Press, 1986).

⁴⁸ Ladd-Taylor, “Hull House Goes to Washington,” 111.

alike, through every stage in their development. Every household had a vested interest in learning how to best protect their children, and the interaction with the Federal Children's Bureau was the source for that information. Their pamphlets had a circulation in the millions.⁴⁹

And indeed, the letters sent to the Federal Children's Bureau after its creation attest to the fact that women were desperately in need of a clearinghouse for information. In Molly Ladd-Taylor's book *Raising A Baby the Government Way: Letters to the Children's Bureau*, the many inquiries from women all over the country asking about contraception, prenatal care, and how to access information and get medical attention, definitely demonstrated that women who wrote the Federal Children's Bureau thought of it as a personal and useful agency that would respond to their inquiries. And the small staff usually did, even if only sending a pamphlet related to the greatest concerns expressed in the letter.⁵⁰ The Children's Bureau, however, still depended heavily on the local charities of the women who had written them to actually provide any aid.⁵¹ But at least the Bureau provided an avenue of inquiry that was previously lacking, just as other government agencies provided this type of resource to farmers and miners.

In the creation of the Federal Children's Bureau, we see a direct line between the settlement houses and the nation's capitol. Molly Ladd-Taylor wrote that at first "the Children's Bureau functioned more like a social settlement than a government bureaucracy."⁵² Given the broad network that it emerged from, it is no surprise that the agency drew upon many of the same practices and policies of settlement houses, focusing on the child within the environment and linking illness and death to social conditions. The workers of the Bureau also developed

⁴⁹ Lillian D. Wald, "The Idea of the Federal Children's Bureau," in *Readings in the Development of Settlement Work*, ed. Lorene M. Pacey (New York, 1950), 225.

⁵⁰ Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau*.

⁵¹ *Ibid.*, 140.

⁵² Ladd-Taylor, "Hull House Goes to Washington," 112.

loyalty among the women that they aided by replying directly to letters and by sending money of their own to help those who were truly desperate. Just like settlement houses, the Bureau became a hub for a network of resources, and in their replies workers of the Bureau often referred women to specific local charities or directed them to medical care.

The Bureau's first chief, Julia Lathrop, was a noted reformer who was first motivated to join settlement house work by meeting Jane Addams and Ellen Starr when they came to speak at Rockford Seminary about "a new Toynbee Hall" during the 1888-1889 academic year. In 1890, Lathrop became a Hull House resident and began an active career in social work helping children, the poor, and the mentally ill. Jane Addams wrote a biography of Lathrop entitled *My Friend, Julia Lathrop* (1935). Taft appointed Lathrop to the Bureau, making her the first woman bureau chief in the federal government.

Her successor, Grace Abbott, earned her masters thesis in Political Science from the University of Chicago, and through Sophonisba Breckinridge, was appointed to the Chicago Immigrants' Protective League. Grace and her sister Edith both lived at Hull House and were close associates with Jane Addams. Abbot joined the staff of the Children's Bureau in 1917, and took over the directorship in 1921 after Lathrop's retirement. Abbott was the administrator of the Sheppard-Towner Act that had passed the same year. When Frances Perkins, another former Hull House resident, was made Secretary of Labor in 1933, Abbott felt the Bureau would be well protected with her in the position, so she retired from the Bureau in 1934. Dr. S. Josephine Baker, too, moved to the Federal Children's Bureau. After working for many years as the Director of the Bureau of Child Hygiene of the New York City Department of Health, in 1924,

Dr. Baker was appointed to work in the Children's Bureau as the Consulting Director in Maternity and Infancy and Child Hygiene.⁵³

Reform work provided many opportunities for educated and experienced women to use their skills in a professional capacity in both the private and public sector; but we can also see that the efforts of women like Wald and Baker were genuinely put forth for the benefit of children, not just for themselves. They saw themselves as the best administrators of these agencies because they had been working in the field at every level for many years, and for much of that time, the only ones working to promote the interests of these populations. Although the settlement house was indeed a launching pad for many professional careers, it was also a place to mobilize. The settlement house brought together interested and motivated people who created a strong network that would eventually extend to the federal level.

Lillian Wald had been the first to suggest that an agency like the Children's Bureau was necessary at the federal level. Wald told and retold the story of the idea for the Federal Children's Bureau over the span of thirty years, but she always claimed that this idea was a reaction to something so seemingly small and unrelated as a federal campaign against the boll weevil.⁵⁴ As I described in chapter one, Wald said it all began one morning sitting at the Henry Street breakfast table; she had gone through the daily mail and found it filled with entreaties from parents looking for help for their children. Then, while reading the newspaper, she noticed that the Secretary of Agriculture was heading south to investigate the boll weevil infestation.

⁵³ "News Notes," *The Public Health Nurse* XVI, no. 1 (January 1924): 54.

⁵⁴ Wald, *The House on Henry Street*, 163–168; Wald, "The Idea of the Federal Children's Bureau," 222–225.

Wald was outraged that the government had not given attention to the nation's most valuable crop, its children, while their concern for cotton and pigs warranted a federal inquiry. She mentioned this to Florence Kelley, sitting across from her at the table, who took such a comment as a challenge to act. "And out of that conversation, still at our coffee cups, was evolved the hope that some day we would be really civilized, we would really know values, and have a bureau in the federal government as keen to ascertain menaces to our crop of children as we have been keen to observe menaces to our cotton crops."⁵⁵ They sent a note to President Teddy Roosevelt, and the next morning Wald was at the White House to discuss the idea with the supportive president.⁵⁶

Lillian Wald truly believed the federal government needed to be involved in the lives of children, even in such a limited function as information-gathering. For Wald, the future of the nation depended on the adequate care of its resources. And while the government had made bureaus to deal with questions about "mines and forests, hogs and lobsters," the most precious of its assets were ignored. "I ask you to consider whether this call for the children's interests does not imply the call for our country's interests. Can we afford to take it? Can we afford not to take

⁵⁵ Wald, "The Idea of the Federal Children's Bureau," 223.

⁵⁶ In her own 1905 book, *Some Ethical Gains Through Legislation*, Kelley wrote, "If the right to childhood is recognized, it follows that the welfare of the children is a legitimate interest of the nation, for the right rests upon the future citizenship of the children." Therefore, she argued, a "Commission for Children" should be established "whose functions should be to correlate, make available, and interpret the facts concerning the physical, mental and moral condition and prospects of the children of the United States, native and immigrant." She especially thought that this could help to alleviate child labor, since the lack of legislative unity between states made it impossible to create strong protections for children. And, like Wald, Kelley saw the Department of Agriculture as a model for this agency. "It should do for the states, cities and smaller communities what the Department of Agriculture does for the farmers,— make accessible to them the latest word of science and the latest methods of applying it." Florence Kelley, *Some Ethical Gains through Legislation* (New York; London: Macmillan & Company, 1905), 99–104. Wald, however, thought a commission was insufficient, and what was needed was a dedicated bureau.

it? For humanity, for social well-being, for the security of the Republic's future, let us bring children into the sphere of our national care and solicitude."⁵⁷

The government had created agencies to investigate conditions and make recommendations for other natural resources, and Wald emphasized in her pleas for the bureau the importance of children for the future of the nation, that they were the most valuable natural resources, and thus the federal government needed to provide them with the same amount of protection. Although private agencies were effective in some areas, she argued that the appropriate kinds of statistics and information could not be effectively gathered by private agencies, and was "too vital to be left to that chance. Only the federal government can cover the whole field and tell us of the children with as much care as it tells of the trees or the fishes or the cotton crop!"⁵⁸

Wald argued the Children's Bureau would bring children under federal care in a way that it had not at all in the past. "It would fix upon the government the responsibility," she wrote.⁵⁹ According to Wald, the government thus far had displayed utter cold indifference to the plight of children. In another text, she wrote: "In eons to come the historian, looking for the federal enactment of the day, will probably make the deductions that the continent was entirely inhabited by fishes, birds, and four-legged animals, and creatures on two legs over five feet high, for there will be very little evidence of the existence of a human species of lower stature."⁶⁰ Other European countries had already instituted "efficient guardianship of their children," while the

⁵⁷ Lillian D. Wald et al., "The Federal Children's Bureau a Symposium," *Annals of the American Academy of Political and Social Science* 33 (March 1909): 28.

⁵⁸ *Ibid.*, 26.

⁵⁹ Wald et al., "The Federal Children's Bureau a Symposium." Wald's speech can also be found in: Clare Coss, ed., *Lillian Wald: Progressive Activist* (New York: Feminist Press at the City University of New York, 1989), 67–71.

⁶⁰ Wald, "The Idea of the Federal Children's Bureau," 224.

United States had not.⁶¹ But Wald wanted to convince others that it was indeed the task of the government. “The full responsibility for the wise guardianship of these children lies upon us. We cherish belief in the children, and hope, through them, for the future. But no longer can a civilized people be satisfied with the casual administration of that trust. Does not the importance of this call for the best statesmanship that our country can produce?”⁶²

The request for the creation of the Children’s Bureau revealed the emphasis on expertise and efficiency that had become the hallmark of Progressive reform. Wald argued that this agency would not duplicate the work of any other agency at any level of government, and instead would increase efficiency by bringing all of these other sources of information under the aegis of one federal bureau, therefore making the information usable. Experts on children’s health and welfare would staff the bureau and perform scientific studies. “Proceeding by the experience of other scientific bodies there would be ample justification for employing the best minds of the country for the application of the knowledge gained, by using the stimulus of suggestion and education. It takes no stretch of the imagination to believe that, with the light of knowledge turned by responsible experts upon all phases of the problem of the child, the American people could be trusted...for what appears to be national apathy is not really so in fact.”⁶³ The Bureau would provide information for individual states to take action, and serve as a mediating point between all of these differing regions suffering from remarkably similar problems. Just as Jane Addams wrote, it was somewhat ridiculous to try to fight industrial problems, for example, state by state, when the overarching issues creating them were mostly the same. With one bureau, they

⁶¹ Clare Coss, ed., “Address to the House Committee Hearing on Establishing a Federal Children’s Bureau,” in *Lillian D. Wald, Progressive Activist* (New York: Feminist Press at the City University of New York, 1989), 67–71.

⁶² Wald et al., “The Federal Children’s Bureau a Symposium,” 28.

⁶³ *Ibid.*, 27.

could begin to study the commonalities of these problems across state lines, gathering a research database that could be accessed, and others could follow the examples of successful programs so that each new attempt didn't start blindly.

Wald seemed to blame a lack of knowledge and statistics for the lack of action on the part of the government to aid children. "Ours is, for example, the only great nation which does not know how many children are born and how many die each year within its borders; still less do we know how many die in infancy of preventable diseases; how many blind children might have seen the light, for one fourth of the totally blind need not have been so had the science that has proved this made been made known in even the remotest sections of the country."⁶⁴ Children should not merely be admired and adored; the issues facing children should be studied, categorized, and catalogued. She wanted the child to be taken "out of the realm of poetry and pure sentiment into the field of scientific, organized care and protection."⁶⁵

The Bureau would not create laws or take action; it would be a place to gather information and statistics, and then to educate. "The Bureau would be a clearing house, a source of information and reliable education on all matters pertaining to the welfare of children and child life, and especially it would investigate and report upon the questions now nowhere answered in complete or unified form, and whose enormous importance to national life is so strikingly evident."⁶⁶

This understanding of the agency shows Wald's optimism that if others *knew*, they would *act*, much like she did when she came to know the circumstances of the East Side when she gave her home nursing class. Wald, and many of the social scientists she worked with in other

⁶⁴ Ibid., 25–26.

⁶⁵ Ibid., 24.

⁶⁶ Ibid.

settlement houses, thought that if everyone were informed of the facts, they too would be compelled to transform policy. In fact, the Bureau would not create any code at all—those decisions would be left to individual states. The federal government’s role in this case was to be a centralized database of information and resources. According to Wald, the Bureau “would introduce no innovation—no new principle—in the function of government. It is along the line of what we have been doing for many years, to promote knowledge...”⁶⁷

Wald was not alone in this belief that information alone would influence action. Fellow member of the National Child Labor Committee Leo Arnstein argued that the Bureau’s most important function would be to create publicity. He didn’t mean simply to publish reports, which every agency did, but to gather and disseminate information and make it useful to the public. Arnstein’s version of publicity sounds more like a campaign than a commission’s report. Making the point that the Children’s Bureau would be in no way duplicating the work of the Census Bureau, Arnstein remarked that the Census Bureau was not gathering information that was practicably useful for the pressing issues affecting the lives of children. By the time the reports were out, too much had changed, or the information was simply “inert.” Arnstein argued that the Children’s Bureau would create information that would be instantly usable, and that they would bring it to those who need it most. “The publication that I mean is the grouping of these figures, these dead figures, until they make a living mass, and then not allow them to remain buried there, but send them forth—bring them home to every community that needs them.” For Arnstein, like Wald, legislation was not the utmost priority. “Publicity will do more probably toward

⁶⁷ Ibid., 27.

eliminating evils than legislation,” he wrote. “Turn the light of publicity on these evils and they will disappear of themselves.”⁶⁸

Unfortunately, this view failed to account for the fact that there were plenty of people who knew about these conditions, but actively worked against changing them. Despite the optimism of Wald that knowledge would turn to action, there were powerful forces working against any public health measure at any level, municipal, state, or federal. Baker regularly had to confront the medical profession in her efforts to provide free or low-cost health care for the children of New York City. Although a doctor herself, she did not always agree with the medical organizations that seemed to be more interested in securing their own financial interests than they were in actually maintaining the health of babies, or of anyone else for that matter.

Doctors sometimes objected to the very existence of the Bureau of Child Hygiene and its most basic operations. Programs that might have diminished the profits of doctors were instantly rejected. In 1914, when Dr. S.S. Goldwater and his successor Haven Emerson wanted to set up health clinics modeled after those that provided treatment to children, some physicians objected to the Health Department’s “policy of socialism” and called the programs “ruinous to the business of the medical practitioners of the city.”⁶⁹ And after the Bureau established some baby health stations in Brooklyn, more than thirty doctors from that borough signed a petition and sent it to the Mayor’s office in protest. They were outraged that the Bureau of Child Hygiene was ruining their medical practices by keeping babies well, and insisted that it be abolished for the benefit of the profession. Baker quickly wrote a response to the mayor, stating: “This is the first

⁶⁸ Ibid., 12.

⁶⁹ Duffy, *A History of Public Health in New York City, 1866-1966*, 269.

genuine compliment I have received since the Bureau was established. I am profoundly grateful for the having had an opportunity to see it.” According to Baker, “The only thing that would have done better would have been a similar protest from an undertakers’ association.”⁷⁰ Clearly, many doctors were more concerned about the state of the medical profession than they were about the state of health of their patients if they advocated keeping them sick so that they could have paying customers in their private practices.

Baker had run-ins with other doctors over the certification of midwives as well. Although Baker had plenty of disparaging remarks about the training and competence of many of the midwives (“foreign”, “stupid”, and “ignorant”), she thought the best solution was a slow one that first certified midwives at the most basic level—in order to get their names and addresses—and then slowly trained them and raised standards. From the point of view of other doctors, especially obstetricians, the standards of practice of midwives should not be elevated; rather the best solution would have been to illegitimize midwives and forbid the practice of their trade.⁷¹

Baker at least recognized that women in the tenements were not going to abandon the tradition of having a female helper at their side during the travails of childbirth, for reasons both cultural and financial. Additionally, she saw how helpful well-qualified midwives could be. She argued that a competent midwife was better than a general practitioner at the delivery of babies, since most doctors had very little training in obstetrics. She clashed with the New York Academy of Medicine on this issue. They refused to believe her numbers that revealed that the maternal mortality rate was higher in hospitals than it was for women who delivered at home with midwives, even though their own studies proved this to be true. So she continued to insist that

⁷⁰ Baker, *Fighting for Life*, 140.

⁷¹ *Ibid.*, 113.

registration and licensing of midwives was far better for mothers and babies, even if doctors preferred to eliminate the competition.

Some of the most repugnant displays of the medical profession's self-interest were revealed while doctors from the American Medical Association (AMA) testified in front of Congress against the Promotion of the Welfare and Hygiene of Maternity and Infancy Act, or the Sheppard-Towner Act, which was introduced in 1921 and created maternal and child health care programs at the state level.⁷² The Sheppard-Towner Act was the perfect example of how federal-state cooperation could actually work. It was the nation's first federal grant program for public health; the federal government allotted funds to states if they agreed to match them. The act was legislated in 1921, and by 1927, 45 states plus Hawaii had accepted the conditions of the grant.⁷³ Although states could decide for themselves how they used the funds, in general they were used for the creation of infant welfare and maternity centers that would provide prenatal care for women and checkups for babies after birth, along with educational programming. These centers encouraged women to see doctors or nurses regularly during their pregnancy to provide preventive care rather than waiting for a crisis, and to seek attention for their babies once they

⁷² Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991); Richard A. Meckel, "Save the Babies": *American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*, The Henry E. Sigerist Series in the History of Medicine (Baltimore: Johns Hopkins University Press, 1990); Molly Ladd-Taylor, "Federal Help for Mothers: The Rise and Fall of the Sheppard-Towner Act in the 1920s," in *Gendered Domains: Rethinking Public and Private in Women's History*, ed. Dorothy O Helly and Susan Reverby (Ithaca, N.Y.: Cornell University Press, 1992), 217-27; J. Stanley Lemons, *The Woman Citizen: Social Feminism in the 1920s* (Charlottesville: University Press of Virginia, 1990); Lynne Curry, *Modern Mothers in the Heartland: Gender, Health, and Progress in Illinois, 1900-1930* (Columbus: Ohio State University Press, 1999). Curry's book showed how the Sheppard-Towner Act played out on the state level, particularly in an area like Illinois where a strong state medical society successfully resisted its implementation.

⁷³ U.S. Department of Health, Education, and Welfare and Public Health Service Health Services Administration Bureau of Community Health Services, *Child Health in America* (Washington, D.C.: Government Printing Office, 1976), 32-33.

were born. The Act also provided instruction and advice for a variety of participants involved in the caring for babies, such as midwives, mothers, and “little mothers,” sometimes in one-on-one maternal health conferences with expectant mothers or in classes to instruct midwives.

The Sheppard-Towner Act assisted with the collection of statistics that would help to document both the problems and the solutions of infant morbidity and mortality. Many of the funds went toward the promotion of birth registration in some form. As we learned from the New York City Division of Child Hygiene under Josephine Baker, birth registration and the collection of vital statistics made it possible to track the number of babies that were born and died, but more importantly, allowed public health agencies to contact new mothers as soon as possible so that they could intervene to provide information about how best to prevent illness and follow up with well-baby care. Many states had not yet developed a systematic way to collect this information. Alabama, Arkansas, Louisiana, Missouri, and Tennessee did not establish birth registration until 1927. Colorado, Georgia, and Oklahoma joined in by 1928; and finally in 1929, Nevada, New Mexico, and the Territory of Hawaii began.⁷⁴ With the Federal Children’s Bureau as a central clearinghouse for this information, these kinds of statistics could be gathered at the national level rather than trying to piece them together state-by-state.

Sheppard-Towner also provided job opportunities for public health nurses and widely demonstrated the wisdom of preventive care among medical professionals. Sheppard-Towner funds made it possible for Alabama, for example, to double the number of public health nurses that it employed at the local level. When the program began, the state only had 36, and by 1926, they had 74.⁷⁵

⁷⁴ Ibid., 26.

⁷⁵ Ibid., 33.

The AMA's rejection of public health efforts was closely tied with the movement to create a national health care policy in the early twentieth century. In 1916, compulsory health insurance had seemed inevitable in the United States. Europe had embraced it, and doctors prepared themselves for what was sure to come. Germany had passed legislation that covered certain workers as early as 1883, and many other European countries followed suit, including Norway (1909), Great Britain (1911) Russia (1912) and the Netherlands (1913).⁷⁶ The American Association for Labor Legislation (AALL), a group of Progressive scientists, put together a Committee on Social Insurance in 1912 that immediately turned its attention to health insurance as a priority over other forms of social insurance, since sickness was what so often sent workers spiraling into poverty. In 1915, Lillian Wald joined the committee, and shortly after they put forth a model bill that was intended to bring together the best of the German and British systems.⁷⁷ In 1916, President of the American Medical Association, Rupert Blue, said it was likely that health insurance would "constitute the next great step in social legislation."⁷⁸

Early acceptance by doctors was due to a sense of inevitability; furthermore, the National Insurance Act didn't seem to have harmed British doctors financially. But doctors from local and state boards quickly pushed the AMA to create an official statement against any form of compulsory health insurance. The main objection was money; doctors were very resistant to the idea of any plan that was perceived to limit their profits. Once rumors spread (sometimes by representatives of private health insurance companies like Prudential) that British doctors suffered low pay and poor practice, the tide began to turn. Ronald Numbers recounted one joke from the time: "To identify a doctor in any New York crowd...all a person needed to do was 'to

⁷⁶ Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978), 10.

⁷⁷ *Ibid.*, 25.

⁷⁸ *Ibid.*, 52.

whisper “health insurance” in a man’s ear and see whether his hand instinctively goes to his pocket.””⁷⁹

Once the United States entered the war, it gave the opposition side ideological ammunition for their economic motivation. The AALL’s previous formulation of the necessity of health insurance to follow in the footsteps of European leaders made it easy to turn these arguments against them. Because of health insurance’s connection with Germany’s program of “sickness insurance,” any support for compulsory health legislation was open to attack as foreign and unpatriotic. In the midst of heavy WWI propaganda that portrayed Germans as evil, these European models were touted as contrary to the American way of life.⁸⁰

The fight for compulsory health insurance not only failed, but rallied doctors into a more unified position that strengthened their defenses for any future imposition on their profits. Soon the terms “socialized medicine” and “state medicine” would be used repeatedly to counter any efforts to create a comprehensive health program. “State medicine” was “seldom defined precisely but commonly used to designate anything that seemed to infringe on the private practice of medicine.”⁸¹ But health bills failed repeatedly after that not just because of the AMA, argued historian Beatrix Hoffman, but because they were attacked from several sides by groups all looking to protect their own financial interests: doctors, employers, insurance companies, and even some unions.⁸²

⁷⁹ Ibid., 89.

⁸⁰ Beatrix Hoffman, *Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill, NC, USA: University of North Carolina Press, 2001), 45.

⁸¹ Numbers, *Almost Persuaded*, 107.

⁸² Hoffman, *Wages of Sickness*.

The Congressional debates over the appropriations for the Sheppard-Towner Bill also rang the death knell for public health programs. As a reaction against the Sheppard-Towner Bill, the AMA strengthened its position in 1922 against state involvement in medical care:

The American Medical Association hereby declares its opposition to all forms of 'state medicine,' because of the ultimate harm that would come thereby to the public weal through such form of practice. 'State medicine' is hereby defined for the purpose of this resolution to be any form of medical treatment, provided, conducted, controlled or subsidized by the federal or state government, or municipality, excepting such service as provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved and administered under the direction of or by a local county medical society, and are not disapproved by the state medical society of which it is a component part.⁸³

By 1925, The New York State Medical Society declared compulsory health insurance a "dead issue."⁸⁴

Many considered the Sheppard-Towner Bill an "entering wedge" for compulsory health insurance.⁸⁵ Once the AALL came out in support of Sheppard-Towner, it provided fodder for the theory that this was part of a larger scheme to gain even greater ground. Many argued that the reason Sheppard-Towner passed in 1921 was that despite private objections, men in Congress had feared the power of the newly enfranchised women.⁸⁶ And indeed, it seemed that women were, for the most part, unified on this issue, and even got support in women's magazines like *McCall's* and *Good Housekeeping*, as well as *McClure's* and *Atlantic Monthly*.⁸⁷ But by the time

⁸³ Numbers, *Almost Persuaded*, 108.

⁸⁴ *Ibid.*, 109.

⁸⁵ *The Congressional Record*, 67 Congress, 1 Sess. (1921), LXI, Pt. 9, pp. 8759-8760, 8764-8765, 8767; found in: Robert H. Bremner, "Congressional Debate on the Sheppard-Towner Bill, 1921," in *Children and Youth in America: A Documentary History* (Cambridge, Mass: Harvard University Press, 1970), 1010-19.

⁸⁶ Lemons, *The Woman Citizen*, 157.

⁸⁷ *Ibid.*, 158.

the bill came up for renewal, the AMA had garnered more support, and so had many conservative women's groups.

Sheppard-Towner ended in 1929, not because of its failure, but rather due to its success. Just as local doctors were angered by Baker's infant mortality programs taking away business, the American Medical Association was threatened by the federal grant money that was providing free care to pregnant women and babies, taking away the opportunity for private doctors to earn money. They lobbied against the original act and then against its continuation.

Baker was, fortunately, not alone in prizing children's health over financial gain. The response of many physicians to the official viewpoint of the AMA caused a split in the organization, and a group supporting preventive healthcare for children broke off to create the American Academy of Pediatrics in 1930. The Academy adopted this statement of purpose: "To create reciprocal and friendly relations with all professional and lay organizations that are interested in the health and protection of children [and] to foster and encourage pediatric investigation, both clinically and in the laboratory, by individuals and groups."⁸⁸ This was a direct response to the accusations made by the AMA during the hearings, which objected to lay control over medicine.

The Congressional hearings reveal both the profit-driven motives of the medical profession, and the misogyny of both doctors and Congressmen. In Baker's account of the hearings, a representative of a New England Medical Society stated, "We oppose this bill because, if you are going to save the lives of all these women and children at public expense, what inducement will be there for young men to study medicine?" Senator Sheppard responded, "Perhaps I didn't understand you correctly. You surely don't mean that you want women and

⁸⁸ U.S. Department of Health, Education, and Welfare and Public Health Service Health Services Administration Bureau of Community Health Services, *Child Health in America*, 34.

children to die unnecessarily or live in constant danger of sickness so there will be something for young doctors to do?” “Why not? That’s the will of God, isn’t it?”⁸⁹

The strong opposition clearly revealed tensions about gender and politics. Baker spoke on behalf of the Federal Children’s Bureau many times at the request of Julia Lathrop, the Bureau’s first chief. There were many reasons Baker was an important witness, but her professional status was especially useful when the quality of discourse was brought down to the level it often was at these hearings. As Baker put it, “I was called Doctor instead of Miss and so could escape from the eternal remark always coming up among Congressmen about giving money to an old-maid to spend.”⁹⁰ The theme of spinsters and old maids was a constant one in these Congressional hearings. Senator William S. Kenyon, Iowa Republican, called advocates for the act the “old maid brigade.”⁹¹ Besides being called “old maids” they were called “office holding spinsters,” “female celibates,” “derailed menopausics,” “endocrine perverts,” “bolsheviks” and “anarchists,” and basically any other creative name they could think up to insult the women of the Children’s Bureau, often by name and by personal attack.⁹²

The Sheppard-Towner Act faced opposition from women’s groups as well, many of which thought that childless women were just trying to get plum jobs for personal gain. As the *Woman Patriot* published: “Children are now the best political graft in America. They furnish the best possible screen behind which to hide cold-blooded calculated socialist feminist political schemes to raid the United Treasury to supply... ‘new, fat jobs’ plus publicity, prominence and power, to childless bureaucrats and women politicians to ‘investigate and report’ the hard-

⁸⁹ Baker, *Fighting for Life*, 138.

⁹⁰ Ibid., 158.

⁹¹ Lindenmeyer, *A Right to Childhood*, 85. Doris Groshen Daniels, *Always a Sister: The Feminism of Lillian D. Wald* (New York: The Feminist Press at the City University of New York, 1989), 115–116, 145–146.

⁹² Daniels, *Always a Sister: The Feminism of Lillian D. Wald*, 115–116, 145–146.

working, taxpaying, child-bearing mothers of America, under pretense of promoting ‘child welfare’ and ‘saving mothers and babies.’”⁹³

James Reed of Missouri criticized the act for trying to impose government regulation on the natural instinct of a mother raising her child. “It seems to be the established doctrine of this bureau that the only people capable of caring for babies and mothers of babies are ladies who have never had babies. ... I cast no reflection on unmarried ladies. Perhaps some of them are too good to have husbands. But any woman who is too refined to have a husband should not undertake the care of another woman's baby when that other woman wants to take care of it herself. ... Official meddling cannot take the place of mother love. Mother love! ... It is the one great universal passion—the sinless passion of sacrifice. Incomparable in its sublimity, interference is sacrilege, regulation is mockery.”⁹⁴

Perhaps this insistence on the value of “mother love” in the Congress is the reason that Baker balanced the role of mothers and the state so carefully in her autobiography. In it, although she continually attested to the benefits of “state medicine,” she also advocated for “mothering.” This was most clear to her in the case of the foundling homes, where babies received the most up-to-date care in an impeccable environment, yet fully half of them died. “There were the wretched little foundlings dying wholesale under fine hygienic conditions and flourishing... when they began to get care from a maternally minded woman.”⁹⁵ She argued that the babies of the wealthy might die, while those of the poor might thrive, since poor children were often given the maternal affection and care that the children of the rich were not, no matter how carefully measured their silver-spooned feedings were administered. Baker was in most ways a

⁹³ U.S. Department of Health, Education, and Welfare and Public Health Service Health Services Administration Bureau of Community Health Services, *Child Health in America*, 32.

⁹⁴ *Ibid.*, 29.

⁹⁵ Baker, *Fighting for Life*, 121.

scientifically minded person who advocated regular feedings and systematic care, but she still recognized that there was an intangible in the care of children that could not be replaced by medicine and modern hygiene: that of the personal attention and care of a mother, or even a mother substitute. Affection, and “personal attention,” gave babies a “reason for living” that could not be matched by “the best care with all the impersonal efficiency of a well-intentioned machine.”

Baker honestly believed that state medicine would be the inevitable result of the transformations in public health that came about during her lifetime. “State medicine is on its way,” she wrote in 1939. “... Sick people need immediate help, understanding and humanity as much as they need highly standardized and efficient practice. The medical profession is mostly composed of high-minded men, but organized medicine as it exists today in the United States has surrounded the profession with too many taboos and too strong a cult of success to allow it to meet the everyday needs of the mass of the people. I have a real sense of pride in my profession. I know it is moving forward. But I regret the road it has chosen to take.”⁹⁶

Baker acted on behalf of “state medicine” for most of her life, but she made it most clear that she wanted these efforts to extend even further than infant and child health when she discussed the trip she made to Russia in 1934. Though she clearly felt that the Soviet Union was a faulty model in many ways, she still admired their efforts to provide healthcare for every citizen, not matter how flawed it was in its administration. “State medicine is to my mind an ideal, and the sooner it changes from an ideal to a practical reality, the better off the human race will be. ... I have ... done my share to bring state medicine into existence.” Baker, too, expressed

⁹⁶ Ibid., 249.

confidence that others would come around to her most practical understanding. “I am reasonably certain that the next generation will see it immeasurably advanced in the United States.... It is already on its way and it is now too late for any backward step.”⁹⁷

In fact, Baker did not deny that the Bureau of Child Hygiene was a form of state medicine, like many of her colleagues in the AMA had attested. One might have expected her to reject this accusation, but instead she whole-heartedly accepted it; she did not hedge on this issue; she did not justify the role of government maintenance of the health of its citizens in capitalist or moderating terms. She accepted the term “state medicine” and demanded more of it.

She argued that state medicine would benefit the general population and doctors both. She, like many today, pointed out that it was the “small salaried class” who found it very difficult to get care “at a price at all within their power to pay.” “The present cost of medical care is far beyond the capacity of the majority of citizens of this country.”⁹⁸ However, she was a doctor herself, and knew that doctors must make a living. But instead of seeing state medicine as an impediment to that, she argued that it would “provide for both sides.” She had made a career out of state medicine; she had found it rewarding and lucrative, and did not think that working for the government in any way kept doctors from financial success.

Baker did not think that state medicine and democracy were at odds with each other; in fact, she found them necessary complements. She surely did not agree with the autocratic way the Russian system was run. “There will have to be safeguards and concessions to our democratic ideals.” For example, she wanted to have the freedom to choose her own doctor; she did not want the state choosing one for her. But she did not find it outside the realm of possibility for the government to make these options available to the recipients of state medicine. In fact,

⁹⁷ Ibid., 236.

⁹⁸ Ibid., 237.

she seemed to argue that the very nature of democracy required a healthy citizenry. “The failures in the Russian experiment need not discourage us. They are the result of the Russian temperament and the Russian history. They are not an inherent feature of the experiment itself, In any case a civilization which insists upon compulsory education must logically insist upon compulsory health of the children it educates.”⁹⁹

Baker made this call for state medicine at the end of her life, when she published her autobiography in 1939, just four years before her death. But she really began to articulate this belief in the role of the government in the nation’s health by at least the end of World War I.¹⁰⁰ She had witnessed the draw of resources from within domestic borders to aid those abroad, even though children in the United States were suffering just as badly from the war’s increase in the price of food. She was disheartened by the fact that one could also only gain interest in the plight of children by referring to them in terms of war resources. In a time when reform was waning and social conservatism was taking its place, Baker was advocating for broader reaching reforms than ever before; she was making a call for a national program of healthcare for children.

Historians have previously noted the arc from settlement houses to the Federal Children’s Bureau, but they have overlooked its crucial intermediary stop: the first “municipalized” school nursing program in the world. School nurses demonstrated the effectiveness of implementing settlement house programs that could eventually be utilized and paid for by the state. Allies in the municipal government like Dr. Baker were able to expand upon those efforts to create new

⁹⁹ Ibid.

¹⁰⁰ S. Josephine Baker, *Reconstruction and the Child*, vol. 74, Reprint Series / Department of Health of the City of New York (New York: Dept. of Health, 1919).

programs for children's health, and established city agencies like the Bureau of Child Hygiene that provided a model for even larger, more comprehensive programs. One can see the spirit of school nursing in the creation of every new state agency devoted to the health of children; Wald's school nursing experiment moved public health from neighborhood to nation.

Conclusion:

Unfinished Business

“We should have, and in the not distant future shall have, compulsory health, as well as compulsory education, for our citizens in the making.”¹ This statement, more than any other exploratory reading, drove me to study the origins of school nursing. Written in 1918 by Helen Winifred Kelly of Chicago and Mabel Bradshaw of Milwaukee in *A Handbook for School Nurses*, it was not merely hopeful, but expectant. It turned out to be, to say the least, overly optimistic. I shook my head and sputtered sad, silent sighs right there in Special Collections. The hopes for school nursing were so high, but more importantly, the link was made immediate between education and health, two fundamental rights in a democracy. Nearly one hundred years later, the ideal of recognizing healthcare as an essential right on par with education has yet to be realized; in fact, education continues to be challenged rather than healthcare expanded.

I can now see why they had so much hope in 1918: Wald’s innovative program, successfully enacted by Lina Rogers, was integrated into municipal policy with the aid of Dr. Josephine Baker. Wald called school nursing the “ancestor” of the Bureau of Child Hygiene, and once established, this agency would be emulated in other cities and states, and even by the Federal Children’s Bureau in 1912. Together, these women were able to save thousands of infant lives per year, and to keep children in school. For a few brief years, school nursing had looked like the key success that would propel public health onto its trajectory toward a national healthcare agenda. But as the 1920s went on, many

¹ Helen Winifred Kelly and Mabel C. Bradshaw, *A Handbook for School Nurses* (New York: Macmillan, 1918).

of these programs would be challenged and shut down; women lost control over the Children's Bureau, and the American Medical Association stood in the way of "socialized medicine" at every turn.

Lillian Wald resigned as Director of the Henry Street Settlement in 1930, and in 1933, Helen Hall came from leading the University Settlement House in Philadelphia to take the position. Wald died in 1940, and in 1944, the two parts of the settlement legally split; the Henry Street Settlement House and the Visiting Nurse Service of New York were formed as separate corporations. It would have been heartbreaking for Lillian Wald, who always imagined these two services as intertwined in a common mission. Her looming presence as Emeritus Director no doubt prevented this from occurring during her lifetime.

The Henry Street Visiting Nurse Service at first just changed its designation from "Nurses' Settlement" to "Settlement House" after its first few years to toughen up their team names in the youth sports leagues, but as the settlement house continued to multiply its programs, the nursing service did indeed become only one small part. Even as the settlement houses expanded their services, they weakened in influence after WWI, and lost their place in a national conversation; they now identify as "neighborhood centers."² Some state services are brokered through these private agencies; low-income families in need of health insurance for their children can go to Henry Street to get help filling out their forms for New York's Child Health Plus. But instead of a vastly expanded network of social security, what we have is a federal-state system of limited social services that

² Judith Ann Trolander, *Professionalism and Social Change: From the Settlement House Movement to Neighborhood Centers, 1886 to the Present* (New York: Columbia University Press, 1987).

are administered through non-profits, and even for those few services, only the poorest of the poor qualify. This remains the same as in the earliest days of Henry Street, when Wald wanted to make sure that all families, especially the ones with moderate incomes, could get care on a sliding scale.

The Visiting Nurse Service of New York continues to provide nursing care in homes. Programs called “Corporate Services” that include immunization setups, screenings, and educational workshops are the modern equivalent of “industrial nursing,” Wald’s program to bring healthcare into workplaces.³ The goals remain the same as they did in the past with Mother Met: provide funding for Henry Street’s free or low-cost services by bringing in money from businesses, while lowering costs for employers who would otherwise lose their workers’ time through illness and absenteeism. The Visiting Nurse Service of New York also provides a variety of pay options, and when prescribed by a doctor, services are covered by most insurance, including Medicare and Medicaid. They also continue to provide nursing service for those who cannot pay, which now has the unfortunate term “charitable care.”⁴

School nurses continue to provide crucial services in schools, despite the cutbacks they face in many districts throughout the country. The National Association of School Nurses reported that a quarter of all schools do not have a school nurse. In those that do, financial constraints mean that sometimes a nurse is not always on duty, since a single nurse might be shared between multiple schools, leaving teachers to administer life-

³ “Partners in Care: Corporate Programs and Services,” accessed December 30, 2013, <http://www.partnersincareny.org/pages/corporate-programs-and-services>.

⁴ “Charitable Care - Visiting Nurse Service of New York,” accessed January 9, 2014, <http://www.vnsny.org/our-services/payment-options/charitable-care/>.

saving procedures for the increasing number of students with asthma and food allergies.⁵ The school nurse also performs an administrative role, and documents whether children are receiving proper care outside the school by collecting physical forms and vaccination records. When an accident or illness happens at school, the nurse will record it carefully, and then call the parents of the child to tell them what to look out for and when to call a doctor. Despite the lack of home visiting, the school nurse is still often the most frequent call from the school for most parents. Some school nurses still gather spare boots and snow pants to have on hand for those children who might not have them. That said, school nurses do not take on the expansive role in health education and maintenance that earlier nurses had imagined within the realm of possibility when articulating their hopes for the future.

Helen Hall served as Henry Street's Head Worker from 1933-1967. Hall was not a nurse, but identified as a social worker after attending the New York School of Social Philanthropy for a year in 1915. As a "second generation social reformer," she was active in the era that was beginning to see women lose ground in the profession as men were encouraged to take the lead in social work.⁶ As director at University Settlement in Philadelphia, she had focused on the effects of unemployment, making her the expert on the crisis that would most devastate Americans during the Great Depression.

⁵ Wendy W. Nielsen and Kathy Lindsey, "When There Is No School Nurse--Are Teachers Prepared for Students with Peanut Allergies?," *School Nurse News* 27, no. 1 (January 2010): 12-15; Michael Tomsic, "No, The School Nurse Is Not In," *NPR.org*, January 3, 2012, <http://www.npr.org/2012/01/03/144615747/no-the-school-nurse-is-not-in>; Vicki Taliaferro, "Where, Oh Where, Are the School Nurses? Staffing in School Health Services Programs," *NASN School Nurse* 20, no. 4 (July 1, 2005): 16-20.

⁶ Janice Andrews, "Helen Hall (1892-1982): A Second Generation Settlement Leader," *Journal of Sociology and Social Welfare* 19 (1992): 95; Susan Ware, *Beyond Suffrage, Women in the New Deal* (Cambridge, Mass: Harvard University Press, 1981).

Hall published her own account of leading Henry Street entitled *Unfinished Business in Neighborhood and Nation* (1971).⁷ Hall was active during Roosevelt's creation of New Deal social policies; in the early 1930s, FDR asked her to serve on the Advisory Council of the President's Committee on Economic Security. National health insurance had already been tabled because "it was felt that it would jeopardize the Social Security Program." Even discussion of its postponement had raised the hackles of the American Medical Association, who immediately called a meeting "in which they passed a resolution opposing government health insurance." In addition, Hall noted, it was "at the same time they also passed a resolution opposing maternal and child health services to be administered by the Children's Bureau." Hall lamented, "Then began the long political fight, continuing to this day, against health insurance that has kept the American people from attaining security against sickness, the third great hazard poor people face, along with unemployment and old age. The President got only 'two-thirds of the cherry.'"⁸

Her account revealed what we already know: that many of the goals of the early Henry Street Visiting Nursing Service went unmet. Wald thought that school nursing would be the beginning of a greater sense of public responsibility towards the health of not just children, but all citizens. But despite the many efforts to demonstrate the importance of having a healthy populace, and the nudging forward of municipal and state programs, in the end, a complete national health insurance program has still not been

⁷ Helen Hall, *Unfinished Business: In Neighborhood and Nation* (New York, Macmillan, 1971).

⁸ *Ibid.*, 54–55.

secured. Most Americans still think of health as primarily an individual, private attainment rather than a community responsibility.

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